AN ACT concerning regulation.

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

ARTICLE 1.

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

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

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

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

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

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

ARTICLE 5.

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

(5 ILCS 100/5-45.35 new)

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

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

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

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

(20 ILCS 301/55-30)

Sec. 55-30. Rate increase.

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

provisions of this Section.

(b) (Blank).

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

(1) Admission and Discharge Assessment.

(2) Level 1 (Individual).

(3) Level 1 (Group).

(4) Level 2 (Individual).

(5) Level 2 (Group).

(6) Case Management.

(7) Psychiatric Evaluation.

(8) Medication Assisted Recovery.

(9) Community Intervention.

(10) Early Intervention (Individual).

(11) Early Intervention (Group).

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

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5-47 new)

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

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

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

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

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

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

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

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

(4) Consideration of additional administrative time and costs.

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

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

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

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

procedures and data collection.

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

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

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

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

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

(4) Recommendations for and an analysis of the impact

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

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

ARTICLE 10.

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

(5 ILCS 100/5-45.36 new)

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

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

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

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

(305 ILCS 5/5-5.05)

Sec. 5-5.05. Hospitals; psychiatric services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5A-12.7)

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

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

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

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

(c) Graduate medical education.

(1) The calculation of graduate medical education

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

hospitals located in Cook County and $116.21 for hospitals located outside Cook County.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Long term acute care hospitals.

(D) Freestanding psychiatric hospitals.

(E) Freestanding rehabilitation hospitals.

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

(G) High Medicaid hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Each hospital in the class shall have a

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

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

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

(4) Definitions. As used in this subsection:

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

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

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

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

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

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

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

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

(A) Hospital inpatient services for critical access hospitals.

(B) Hospital outpatient services for critical access hospitals.

(C) Hospital inpatient services for public hospitals.

(D) Hospital outpatient services for public hospitals.

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

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

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

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

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

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

Department shall direct MCOs to make payments as follows:

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

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

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

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

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

quarter.

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

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

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

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

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

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

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

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

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

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

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

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

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

its website by November 15, 2022.

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

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

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

Definitions. As used in this subsection:

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

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

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

is calculated each quarter by summing the relative weight of all inpatient Diagnosis-Related Group (DRG) claims for a category of service in the applicable Determination Quarter and dividing the sum by the number of sum total of all inpatient DRG admissions for the category of service for the associated claims. The case mix index for outpatient claims is calculated each quarter by summing the relative weight of all paid EAPGs in the applicable Determination Quarter and dividing the sum by the sum total of paid EAPGs for the associated claims.

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

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

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

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

(j) Pass-through payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/12-4.105)

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

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

(305 ILCS 5/14-12)

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

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

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

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

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

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

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

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

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

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

(7.5) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Phase 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) Entities eligible to be funded.

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

(ii) The Department shall prioritize

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

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

to projects that are a collaboration between hospitals and other providers in distressed areas of the State designed to address specific healthcare disparities, $15,000,000 to collaborations between critical access hospitals and other providers designed to address specific healthcare disparities, and $15,000,000 to cross-provider collaborations designed to address specific healthcare disparities, and $5,000,000 to collaborations that focus on workforce development.

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

(v) The Department shall take steps to ensure

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

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

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

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

Section.

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

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

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

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

progress.

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

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

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

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

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

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

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

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

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

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

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

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

(3) (Blank).

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

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

Committee is dissolved on April 1, 2019.

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

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/14-12.5 new)

Sec. 14-12.5. Hospital rate updates.

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

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

(1) For inpatient general acute care services, the

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

(2) For inpatient psychiatric services:

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The Department shall take all actions necessary to

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

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

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

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

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

(305 ILCS 5/14-12.7 new)

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

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

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

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

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

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

ARTICLE 15.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notwithstanding any other law to the contrary, the

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

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

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

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

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

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

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

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

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

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

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

exceptions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subject to approval by the federal Centers for Medicare

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

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

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

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

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

ARTICLE 20.

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

(305 ILCS 5/5-5.01a)

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

(a) The Department shall establish and provide oversight for a program of supportive living facilities that seek to

promote resident independence, dignity, respect, and well-being in the most cost-effective manner.

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

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

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

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

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

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

Subject to federal approval, beginning January 1, 2024, the dementia care rate for supportive living services must be no less than the non-dementia care supportive living services

rate multiplied by 1.5.

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

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

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

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

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

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

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

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

receive the enhanced federal medical assistance percentage. (Source: P.A. 101-10, eff. 6-5-19; 102-43, eff. 7-6-21; 102-699, eff. 4-19-22.)

ARTICLE 25.

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

(305 ILCS 5/12-4.57 new)

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

ARTICLE 30.

Section 30-5. The Specialized Mental Health Rehabilitation

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

(210 ILCS 49/5-107)

Sec. 5-107. Quality of life enhancement. Beginning on July 1, 2019, for improving the quality of life and the quality of care, an additional payment shall be awarded to a facility for their single occupancy rooms. This payment shall be in addition to the rate for recovery and rehabilitation. The additional rate for single room occupancy shall be no less than $10 per day, per single room occupancy. The Department of Healthcare and Family Services shall adjust payment to Medicaid managed care entities to cover these costs. Beginning July 1, 2022, for improving the quality of life and the quality of care, a payment of no less than $5 per day, per single room occupancy shall be added to the existing $10 additional per day, per single room occupancy rate for a total of at least $15 per day, per single room occupancy. <u>For improving the quality of life and the quality of care, on January 1, 2024, a payment of no less than $10.50 per day, per single room occupancy shall be added to the existing $15 additional per day, per single room occupancy rate for a total of at least $25.50 per day, per single room occupancy.</u> Beginning July 1, 2022, for improving the quality of life and the quality of care, an additional payment shall be awarded to a facility for its dual-occupancy rooms. This payment shall be in addition to the rate for recovery and rehabilitation. The additional rate for

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

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

ARTICLE 35.

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

(305 ILCS 5/5-2b)

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

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

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

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

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

ARTICLE 40.

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

changing Section 5-5.2 as follows:

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

Sec. 5-5.2. Payment.

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

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

(c) (Blank).

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

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

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

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

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

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

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

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

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

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

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

point until the facilities reach a per diem add-on of $23.80. Facilities with at least 92% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $23.80, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $29.75. Facilities with at least 100% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $29.75, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $35.70. Facilities with at least 110% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $35.70, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $38.68. Facilities with at least 125% or higher of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $38.68. Beginning April 1, 2023, no nursing facility's variable staffing per diem add-on shall be reduced by more than 5% in 2 consecutive quarters. For the quarters beginning July 1, 2022 and October 1, 2022, no facility's variable per diem staffing add-on shall be calculated at a rate lower than 85% of the staffing indicated by the STRIVE study. No facility below 70% of the staffing indicated by the STRIVE study shall receive a variable per diem staffing add-on after December 31, 2022.

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

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

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

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

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

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

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

diem multiplied by 0.80; or

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

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

(1) Base rate spending pool shall be:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e-1) (Blank).

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

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

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

(f) (Blank).

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

(1) (Blank);

(2) (Blank);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(F) The Department shall disburse quality pool

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

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

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

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

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

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

ARTICLE 45.

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

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

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

(a) (blank);

(b) (blank);

(c) home care aide services;

(d) personal assistant services;

(e) adult day services;

(f) home-delivered meals;

(g) education in self-care;

(h) personal care services;

(i) adult day health services;

(j) habilitation services;

(k) respite care;

(k-5) community reintegration services;

(k-6) flexible senior services;

(k-7) medication management;

(k-8) emergency home response;

(l) other nonmedical social services that may enable the person to become self-supporting; or

(m) clearinghouse for information provided by senior citizen home owners who want to rent rooms to or share living space with other senior citizens.

The Department shall establish eligibility standards for such services. In determining the amount and nature of services for which a person may qualify, consideration shall not be given to the value of cash, property or other assets held in the name of the person's spouse pursuant to a written agreement dividing marital property into equal but separate shares or pursuant to a transfer of the person's interest in a home to his spouse, provided that the spouse's share of the marital property is not made available to the person seeking such services.

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

rules promulgated by the Department.

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) bathing;

(B) grooming;

(C) toileting;

(D) nail care;

(E) transferring;

(F) respiratory services;

(G) exercise; or

(H) positioning;

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

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

services and all increases in the services cost maximum;

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

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

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

January 1, 2014 in order to address these improvements;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In regard to community care providers, failure to comply

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) One individual from a statewide association

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

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

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

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

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

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

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

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

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

number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program and are enrolled in the State's Medical Assistance Program; (B) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program, but are not enrolled in the State's Medical Assistance Program; and (C) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program and are eligible for benefits under the State's Medical Assistance Program, but are not enrolled in the State's Medical Assistance Program. In addition to this data, the Department on Aging shall provide the Subcommittee with plans on how the Department on Aging will reduce the number of Illinois residents who are not enrolled in the State's Medical Assistance Program but who are eligible for medical assistance benefits. The Department on Aging shall enroll in the State's Medical Assistance Program those Illinois residents who receive services under the Community Care Program and are eligible for medical assistance benefits but are not enrolled in the State's Medicaid Assistance Program. The data provided to the Subcommittee shall be made available to the public via the Department on Aging's website.

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

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

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

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

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

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

Subcommittee shall dissolve.

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

ARTICLE 50.

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

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

Sec. 5-5.2. Payment.

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

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

(c) (Blank).

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

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

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

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

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

Reference Date of the Minimum Data Set (MDS).

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

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

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

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

Facilities with at least 70% of the staffing indicated

by the STRIVE study shall be paid a per diem add-on of $9, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem of $14.88. Facilities with at least 80% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $14.88, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $23.80. Facilities with at least 92% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $23.80, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $29.75. Facilities with at least 100% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $29.75, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $35.70. Facilities with at least 110% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $35.70, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $38.68. Facilities with at least 125% or higher of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $38.68. Beginning April 1, 2023, no nursing facility's variable staffing per diem add-on shall be reduced by more than 5% in 2 consecutive quarters. For the quarters beginning July 1, 2022 and October 1, 2022, no facility's variable per

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

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

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

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

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

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

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

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

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

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

(1) Base rate spending pool shall be:

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

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

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

(2) For each nursing home with Medicaid residents as

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e-1) (Blank).

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

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

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

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

(f) (Blank).

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

adjusted as follows:

(1) (Blank);

(2) (Blank);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 55.

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

(305 ILCS 5/5-5i new)

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

ARTICLE 60.

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

(305 ILCS 5/5-35.5 new)

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

ARTICLE 65.

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

(305 ILCS 66/20-10)

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

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

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

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

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

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

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

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

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

(5) Medicaid user-based directed payments.

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

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

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

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

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

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

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

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

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

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

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

(c) The following payment adjustments shall be made:

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

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

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

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

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

(E) Family Therapy, $500,000;

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

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

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

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

(d) Rate simplification for team-based services.

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

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

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

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

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

(305 ILCS 66/20-20)

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

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

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

(b) For directed payments under subsection (b) of Section 20-10:~~.~~

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

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

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

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

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

(305 ILCS 66/20-22 new)

Sec. 20-22. Implementation plan for cost reporting.

(a) For the purpose of understanding behavioral health services cost structures and their impact on the Illinois Medical Assistance Program, the Department shall engage stakeholders to develop a plan for the regular collection of cost reporting for all entity-based providers of behavioral

health services reimbursed under the Rehabilitation or Prevention authorities of the Illinois Medicaid State Plan. Data shall be used to inform on the effectiveness and efficiency of Illinois Medicaid rates. The plan at minimum should consider the following:

(1) alignment with certified community behavioral health clinic requirements, standards, policies, and procedures;

(2) inclusion of prospective costs to measure what is needed to increase services and capacity;

(3) consideration of differences in collection and policies based on the size of providers;

(4) consideration of additional administrative time and costs;

(5) goals, purposes, and usage of data collected from cost reports;

(6) inclusion of qualitative data in addition to quantitative data;

(7) technical assistance for providers for completing cost reports including initial training by the Department for providers; and

(8) an implementation timeline that allows an initial grace period for providers to adjust internal procedures and data collection.

Details from collected cost reports shall be made publicly available on the Department's website and costs shall be used

to ensure the effectiveness and efficiency of Illinois Medicaid rates.

(b) The Department and stakeholders shall develop a plan by April 1, 2024. The Department shall engage stakeholders on implementation of the plan.

ARTICLE 70.

Section 70-5. The Illinois Public Aid Code is amended by changing Section 5-4.2 as follows:

(305 ILCS 5/5-4.2)

Sec. 5-4.2. Ambulance services payments.

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

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

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

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

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

Systems Act.

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

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

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

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

(d) This Section does not prohibit separate billing by

ambulance service providers for oxygen furnished while providing advanced life support services.

(e) Beginning with services rendered on or after July 1, 2008, all providers of non-emergency medi-car and service car transportation must certify that the driver and employee attendant, as applicable, have completed a safety program approved by the Department to protect both the patient and the driver, prior to transporting a patient. The provider must maintain this certification in its records. The provider shall produce such documentation upon demand by the Department or its representative. Failure to produce documentation of such training shall result in recovery of any payments made by the Department for services rendered by a non-certified driver or employee attendant. Medi-car and service car providers must maintain legible documentation in their records of the driver and, as applicable, employee attendant that actually transported the patient. Providers must recertify all drivers and employee attendants every 3 years. If they meet the established training components set forth by the Department, providers of non-emergency medi-car and service car transportation that are either directly or through an affiliated company licensed by the Department of Public Health shall be approved by the Department to have in-house safety programs for training their own staff.

Notwithstanding the requirements above, any public transportation provider of medi-car and service car

transportation that receives federal funding under 49 U.S.C. 5307 and 5311 need not certify its drivers and employee attendants under this Section, since safety training is already federally mandated.

(f) With respect to any policy or program administered by the Department or its agent regarding approval of non-emergency medical transportation by ground ambulance service providers, including, but not limited to, the Non-Emergency Transportation Services Prior Approval Program (NETSPAP), the Department shall establish by rule a process by which ground ambulance service providers of non-emergency medical transportation may appeal any decision by the Department or its agent for which no denial was received prior to the time of transport that either (i) denies a request for approval for payment of non-emergency transportation by means of ground ambulance service or (ii) grants a request for approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than the ground ambulance service provider would have received as compensation for the level of service requested. The rule shall be filed by December 15, 2012 and shall provide that, for any decision rendered by the Department or its agent on or after the date the rule takes effect, the ground ambulance service provider shall have 60 days from the date the decision is received to

file an appeal. The rule established by the Department shall be, insofar as is practical, consistent with the Illinois Administrative Procedure Act. The Director's decision on an appeal under this Section shall be a final administrative decision subject to review under the Administrative Review Law.

(f-5) Beginning 90 days after July 20, 2012 (the effective date of Public Act 97-842), (i) no denial of a request for approval for payment of non-emergency transportation by means of ground ambulance service, and (ii) no approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than would have been received at the level of service submitted by the ground ambulance service provider, may be issued by the Department or its agent unless the Department has submitted the criteria for determining the appropriateness of the transport for first notice publication in the Illinois Register pursuant to Section 5-40 of the Illinois Administrative Procedure Act.

(f-6) Within 90 days after the effective date of this amendatory Act of the 102nd General Assembly and subject to federal approval, the Department shall file rules to allow for the approval of ground ambulance services when the sole purpose of the transport is for the navigation of stairs or the assisting or lifting of a patient at a medical facility or

during a medical appointment in instances where the Department or a contracted Medicaid managed care organization or their transportation broker is unable to secure transportation through any other transportation provider.

(f-7) For non-emergency ground ambulance claims properly denied under Department policy at the time the claim is filed due to failure to submit a valid Medical Certification for Non-Emergency Ambulance on and after December 15, 2012 and prior to January 1, 2021, the Department shall allot $2,000,000 to a pool to reimburse such claims if the provider proves medical necessity for the service by other means. Providers must submit any such denied claims for which they seek compensation to the Department no later than December 31, 2021 along with documentation of medical necessity. No later than May 31, 2022, the Department shall determine for which claims medical necessity was established. Such claims for which medical necessity was established shall be paid at the rate in effect at the time of the service, provided the $2,000,000 is sufficient to pay at those rates. If the pool is not sufficient, claims shall be paid at a uniform percentage of the applicable rate such that the pool of $2,000,000 is exhausted. The appeal process described in subsection (f) shall not be applicable to the Department's determinations made in accordance with this subsection.

(g) Whenever a patient covered by a medical assistance program under this Code or by another medical program

administered by the Department, including a patient covered under the State's Medicaid managed care program, is being transported from a facility and requires non-emergency transportation including ground ambulance, medi-car, or service car transportation, a Physician Certification Statement as described in this Section shall be required for each patient. Facilities shall develop procedures for a licensed medical professional to provide a written and signed Physician Certification Statement. The Physician Certification Statement shall specify the level of transportation services needed and complete a medical certification establishing the criteria for approval of non-emergency ambulance transportation, as published by the Department of Healthcare and Family Services, that is met by the patient. This certification shall be completed prior to ordering the transportation service and prior to patient discharge. The Physician Certification Statement is not required prior to transport if a delay in transport can be expected to negatively affect the patient outcome. If the ground ambulance provider, medi-car provider, or service car provider is unable to obtain the required Physician Certification Statement within 10 calendar days following the date of the service, the ground ambulance provider, medi-car provider, or service car provider must document its attempt to obtain the requested certification and may then submit the claim for payment. Acceptable documentation includes a signed return receipt from

the U.S. Postal Service, facsimile receipt, email receipt, or other similar service that evidences that the ground ambulance provider, medi-car provider, or service car provider attempted to obtain the required Physician Certification Statement.

The medical certification specifying the level and type of non-emergency transportation needed shall be in the form of the Physician Certification Statement on a standardized form prescribed by the Department of Healthcare and Family Services. Within 75 days after July 27, 2018 (the effective date of Public Act 100-646), the Department of Healthcare and Family Services shall develop a standardized form of the Physician Certification Statement specifying the level and type of transportation services needed in consultation with the Department of Public Health, Medicaid managed care organizations, a statewide association representing ambulance providers, a statewide association representing hospitals, 3 statewide associations representing nursing homes, and other stakeholders. The Physician Certification Statement shall include, but is not limited to, the criteria necessary to demonstrate medical necessity for the level of transport needed as required by (i) the Department of Healthcare and Family Services and (ii) the federal Centers for Medicare and Medicaid Services as outlined in the Centers for Medicare and Medicaid Services' Medicare Benefit Policy Manual, Pub. 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician Certification Statement shall satisfy the obligations of

hospitals under Section 6.22 of the Hospital Licensing Act and nursing homes under Section 2-217 of the Nursing Home Care Act. Implementation and acceptance of the Physician Certification Statement shall take place no later than 90 days after the issuance of the Physician Certification Statement by the Department of Healthcare and Family Services.

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

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

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

accordance with Section 5-5e.

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

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

(Source: P.A. 101-81, eff. 7-12-19; 101-649, eff. 7-7-20; 102-364, eff. 1-1-22; 102-650, eff. 8-27-21; 102-813, eff. 5-13-22; 102-1037, eff. 6-2-22.)

ARTICLE 75.

Section 75-5. The Illinois Public Aid Code is amended by changing Section 5-5.4h as follows:

(305 ILCS 5/5-5.4h)

Sec. 5-5.4h. Medicaid reimbursement for medically complex for the developmentally disabled facilities licensed under the

MC/DD Act.

(a) Facilities licensed as medically complex for the developmentally disabled facilities that serve severely and chronically ill patients shall have a specific reimbursement system designed to recognize the characteristics and needs of the patients they serve.

(b) For dates of services starting July 1, 2013 and until a new reimbursement system is designed, medically complex for the developmentally disabled facilities that meet the following criteria:

(1) serve exceptional care patients; and

(2) have 30% or more of their patients receiving ventilator care;

shall receive Medicaid reimbursement on a 30-day expedited schedule.

(c) Subject to federal approval of changes to the Title XIX State Plan, for dates of services starting July 1, 2014 through March 31, 2019, medically complex for the developmentally disabled facilities which meet the criteria in subsection (b) of this Section shall receive a per diem rate for clinically complex residents of $304. Clinically complex residents on a ventilator shall receive a per diem rate of $669. Subject to federal approval of changes to the Title XIX State Plan, for dates of services starting April 1, 2019, medically complex for the developmentally disabled facilities must be reimbursed an exceptional care per diem rate, instead

of the base rate, for services to residents with complex or extensive medical needs. Exceptional care per diem rates must be paid for the conditions or services specified under subsection (f) at the following per diem rates: Tier 1 $326, Tier 2 $546, and Tier 3 $735. Subject to federal approval, on and after January 1, 2024, each tier rate shall be increased 6% over the amount in effect on the effective date of this amendatory Act of the 103rd General Assembly. Any reimbursement increases applied to the base rate to providers licensed under the ID/DD Community Care Act must also be applied in an equivalent manner to each tier of exceptional care per diem rates for medically complex for the developmentally disabled facilities.

(d) For residents on a ventilator pursuant to subsection (c) or subsection (f), facilities shall have a policy documenting their method of routine assessment of a resident's weaning potential with interventions implemented noted in the resident's medical record.

(e) For services provided prior to April 1, 2019 and for the purposes of this Section, a resident is considered clinically complex if the resident requires at least one of the following medical services:

(1) Tracheostomy care with dependence on mechanical ventilation for a minimum of 6 hours each day.

(2) Tracheostomy care requiring suctioning at least every 6 hours, room air mist or oxygen as needed, and

dependence on one of the treatment procedures listed under paragraph (4) excluding the procedure listed in subparagraph (A) of paragraph (4).

(3) Total parenteral nutrition or other intravenous nutritional support and one of the treatment procedures listed under paragraph (4).

(4) The following treatment procedures apply to the conditions in paragraphs (2) and (3) of this subsection:

(A) Intermittent suctioning at least every 8 hours and room air mist or oxygen as needed.

(B) Continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent via a peripheral or central line, without continuous infusion.

(C) Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours.

(D) Tube feeding via nasogastric or gastrostomy tube.

(E) Other medical technologies required continuously, which in the opinion of the attending physician require the services of a professional nurse.

(f) Complex or extensive medical needs for exceptional care reimbursement. The conditions and services used for the

purposes of this Section have the same meanings as ascribed to those conditions and services under the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) and specified in the most recent manual. Instead of submitting minimum data set assessments to the Department, medically complex for the developmentally disabled facilities must document within each resident's medical record the conditions or services using the minimum data set documentation standards and requirements to qualify for exceptional care reimbursement.

(1) Tier 1 reimbursement is for residents who are receiving at least 51% of their caloric intake via a feeding tube.

(2) Tier 2 reimbursement is for residents who are receiving tracheostomy care without a ventilator.

(3) Tier 3 reimbursement is for residents who are receiving tracheostomy care and ventilator care.

(g) For dates of services starting April 1, 2019, reimbursement calculations and direct payment for services provided by medically complex for the developmentally disabled facilities are the responsibility of the Department of Healthcare and Family Services instead of the Department of Human Services. Appropriations for medically complex for the developmentally disabled facilities must be shifted from the Department of Human Services to the Department of Healthcare and Family Services. Nothing in this Section prohibits the Department of Healthcare and Family Services from paying more

than the rates specified in this Section. The rates in this Section must be interpreted as a minimum amount. Any reimbursement increases applied to providers licensed under the ID/DD Community Care Act must also be applied in an equivalent manner to medically complex for the developmentally disabled facilities.

(h) The Department of Healthcare and Family Services shall pay the rates in effect on March 31, 2019 until the changes made to this Section by this amendatory Act of the 100th General Assembly have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(i) The Department of Healthcare and Family Services may adopt rules as allowed by the Illinois Administrative Procedure Act to implement this Section; however, the requirements of this Section must be implemented by the Department of Healthcare and Family Services even if the Department of Healthcare and Family Services has not adopted rules by the implementation date of April 1, 2019.

(Source: P.A. 100-646, eff. 7-27-18.)

ARTICLE 80.

Section 80-5. The Illinois Public Aid Code is amended by changing Section 5-4.2 as follows:

(305 ILCS 5/5-4.2)

Sec. 5-4.2. Ambulance services payments.

(a) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1993, the Illinois Department shall reimburse ambulance service providers at rates calculated in accordance with this Section. It is the intent of the General Assembly to provide adequate reimbursement for ambulance services so as to ensure adequate access to services for recipients of aid under this Article and to provide appropriate incentives to ambulance service providers to provide services in an efficient and cost-effective manner. Thus, it is the intent of the General Assembly that the Illinois Department implement a reimbursement system for ambulance services that, to the extent practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, is consistent with the payment principles of Medicare. To ensure uniformity between the payment principles of Medicare and Medicaid, the Illinois Department shall follow, to the extent necessary and practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, the statutes, laws, regulations, policies, procedures, principles, definitions, guidelines, and manuals used to determine the amounts paid to ambulance service providers under Title XVIII of the Social Security Act (Medicare).

(b) For ambulance services provided to a recipient of aid

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

(c) For purposes of this Section, "ambulance services" includes medical transportation services provided by means of an ambulance, medi-car, service car, or taxi.

(c-1) For purposes of this Section, "ground ambulance service" means medical transportation services that are described as ground ambulance services by the Centers for Medicare and Medicaid Services and provided in a vehicle that is licensed as an ambulance by the Illinois Department of Public Health pursuant to the Emergency Medical Services (EMS) Systems Act.

(c-2) For purposes of this Section, "ground ambulance service provider" means a vehicle service provider as described in the Emergency Medical Services (EMS) Systems Act that operates licensed ambulances for the purpose of providing emergency ambulance services, or non-emergency ambulance services, or both. For purposes of this Section, this includes both ambulance providers and ambulance suppliers as described by the Centers for Medicare and Medicaid Services.

(c-3) For purposes of this Section, "medi-car" means transportation services provided to a patient who is confined

to a wheelchair and requires the use of a hydraulic or electric lift or ramp and wheelchair lockdown when the patient's condition does not require medical observation, medical supervision, medical equipment, the administration of medications, or the administration of oxygen.

(c-4) For purposes of this Section, "service car" means transportation services provided to a patient by a passenger vehicle where that patient does not require the specialized modes described in subsection (c-1) or (c-3).

(d) This Section does not prohibit separate billing by ambulance service providers for oxygen furnished while providing advanced life support services.

(e) Beginning with services rendered on or after July 1, 2008, all providers of non-emergency medi-car and service car transportation must certify that the driver and employee attendant, as applicable, have completed a safety program approved by the Department to protect both the patient and the driver, prior to transporting a patient. The provider must maintain this certification in its records. The provider shall produce such documentation upon demand by the Department or its representative. Failure to produce documentation of such training shall result in recovery of any payments made by the Department for services rendered by a non-certified driver or employee attendant. Medi-car and service car providers must maintain legible documentation in their records of the driver and, as applicable, employee attendant that actually

transported the patient. Providers must recertify all drivers and employee attendants every 3 years. If they meet the established training components set forth by the Department, providers of non-emergency medi-car and service car transportation that are either directly or through an affiliated company licensed by the Department of Public Health shall be approved by the Department to have in-house safety programs for training their own staff.

Notwithstanding the requirements above, any public transportation provider of medi-car and service car transportation that receives federal funding under 49 U.S.C. 5307 and 5311 need not certify its drivers and employee attendants under this Section, since safety training is already federally mandated.

(f) With respect to any policy or program administered by the Department or its agent regarding approval of non-emergency medical transportation by ground ambulance service providers, including, but not limited to, the Non-Emergency Transportation Services Prior Approval Program (NETSPAP), the Department shall establish by rule a process by which ground ambulance service providers of non-emergency medical transportation may appeal any decision by the Department or its agent for which no denial was received prior to the time of transport that either (i) denies a request for approval for payment of non-emergency transportation by means of ground ambulance service or (ii) grants a request for

approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than the ground ambulance service provider would have received as compensation for the level of service requested. The rule shall be filed by December 15, 2012 and shall provide that, for any decision rendered by the Department or its agent on or after the date the rule takes effect, the ground ambulance service provider shall have 60 days from the date the decision is received to file an appeal. The rule established by the Department shall be, insofar as is practical, consistent with the Illinois Administrative Procedure Act. The Director's decision on an appeal under this Section shall be a final administrative decision subject to review under the Administrative Review Law.

(f-5) Beginning 90 days after July 20, 2012 (the effective date of Public Act 97-842), (i) no denial of a request for approval for payment of non-emergency transportation by means of ground ambulance service, and (ii) no approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than would have been received at the level of service submitted by the ground ambulance service provider, may be issued by the Department or its agent unless the

Department has submitted the criteria for determining the appropriateness of the transport for first notice publication in the Illinois Register pursuant to Section 5-40 of the Illinois Administrative Procedure Act.

(f-6) Within 90 days after the effective date of this amendatory Act of the 102nd General Assembly and subject to federal approval, the Department shall file rules to allow for the approval of ground ambulance services when the sole purpose of the transport is for the navigation of stairs or the assisting or lifting of a patient at a medical facility or during a medical appointment in instances where the Department or a contracted Medicaid managed care organization or their transportation broker is unable to secure transportation through any other transportation provider.

(f-7) For non-emergency ground ambulance claims properly denied under Department policy at the time the claim is filed due to failure to submit a valid Medical Certification for Non-Emergency Ambulance on and after December 15, 2012 and prior to January 1, 2021, the Department shall allot $2,000,000 to a pool to reimburse such claims if the provider proves medical necessity for the service by other means. Providers must submit any such denied claims for which they seek compensation to the Department no later than December 31, 2021 along with documentation of medical necessity. No later than May 31, 2022, the Department shall determine for which claims medical necessity was established. Such claims for

which medical necessity was established shall be paid at the rate in effect at the time of the service, provided the $2,000,000 is sufficient to pay at those rates. If the pool is not sufficient, claims shall be paid at a uniform percentage of the applicable rate such that the pool of $2,000,000 is exhausted. The appeal process described in subsection (f) shall not be applicable to the Department's determinations made in accordance with this subsection.

(g) Whenever a patient covered by a medical assistance program under this Code or by another medical program administered by the Department, including a patient covered under the State's Medicaid managed care program, is being transported from a facility and requires non-emergency transportation including ground ambulance, medi-car, or service car transportation, a Physician Certification Statement as described in this Section shall be required for each patient. Facilities shall develop procedures for a licensed medical professional to provide a written and signed Physician Certification Statement. The Physician Certification Statement shall specify the level of transportation services needed and complete a medical certification establishing the criteria for approval of non-emergency ambulance transportation, as published by the Department of Healthcare and Family Services, that is met by the patient. This certification shall be completed prior to ordering the transportation service and prior to patient discharge. The

Physician Certification Statement is not required prior to transport if a delay in transport can be expected to negatively affect the patient outcome. If the ground ambulance provider, medi-car provider, or service car provider is unable to obtain the required Physician Certification Statement within 10 calendar days following the date of the service, the ground ambulance provider, medi-car provider, or service car provider must document its attempt to obtain the requested certification and may then submit the claim for payment. Acceptable documentation includes a signed return receipt from the U.S. Postal Service, facsimile receipt, email receipt, or other similar service that evidences that the ground ambulance provider, medi-car provider, or service car provider attempted to obtain the required Physician Certification Statement.

The medical certification specifying the level and type of non-emergency transportation needed shall be in the form of the Physician Certification Statement on a standardized form prescribed by the Department of Healthcare and Family Services. Within 75 days after July 27, 2018 (the effective date of Public Act 100-646), the Department of Healthcare and Family Services shall develop a standardized form of the Physician Certification Statement specifying the level and type of transportation services needed in consultation with the Department of Public Health, Medicaid managed care organizations, a statewide association representing ambulance providers, a statewide association representing hospitals, 3

statewide associations representing nursing homes, and other stakeholders. The Physician Certification Statement shall include, but is not limited to, the criteria necessary to demonstrate medical necessity for the level of transport needed as required by (i) the Department of Healthcare and Family Services and (ii) the federal Centers for Medicare and Medicaid Services as outlined in the Centers for Medicare and Medicaid Services' Medicare Benefit Policy Manual, Pub. 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician Certification Statement shall satisfy the obligations of hospitals under Section 6.22 of the Hospital Licensing Act and nursing homes under Section 2-217 of the Nursing Home Care Act. Implementation and acceptance of the Physician Certification Statement shall take place no later than 90 days after the issuance of the Physician Certification Statement by the Department of Healthcare and Family Services.

Pursuant to subsection (E) of Section 12-4.25 of this Code, the Department is entitled to recover overpayments paid to a provider or vendor, including, but not limited to, from the discharging physician, the discharging facility, and the ground ambulance service provider, in instances where a non-emergency ground ambulance service is rendered as the result of improper or false certification.

Beginning October 1, 2018, the Department of Healthcare and Family Services shall collect data from Medicaid managed care organizations and transportation brokers, including the

Department's NETSPAP broker, regarding denials and appeals related to the missing or incomplete Physician Certification Statement forms and overall compliance with this subsection. The Department of Healthcare and Family Services shall publish quarterly results on its website within 15 days following the end of each quarter.

(h) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(i) Subject to federal approval, on and after January 1, 2024 through June 30, 2026, ~~On and after July 1, 2018,~~ the Department shall increase the base rate of reimbursement for both base charges and mileage charges for ground ambulance service providers not participating in the Ground Emergency Medical Transportation (GEMT) Program for medical transportation services provided by means of a ground ambulance to a level not lower than 140% ~~112%~~ of the base rate in effect as of January 1, 2023 ~~June 30, 2018~~.

(j) For the purpose of understanding ground ambulance transportation services cost structures and their impact on the Medical Assistance Program, the Department shall engage stakeholders, including, but not limited to, a statewide association representing private ground ambulance service providers in Illinois, to develop recommendations for a plan

for the regular collection of cost data for all ground ambulance transportation providers reimbursed under the Illinois Title XIX State Plan. Cost data obtained through this process shall be used to inform on and to ensure the effectiveness and efficiency of Illinois Medicaid rates. The Department shall establish a process to limit public availability of portions of the cost report data determined to be proprietary. This process shall be concluded and recommendations shall be provided no later than April 1, 2024.

(Source: P.A. 101-81, eff. 7-12-19; 101-649, eff. 7-7-20; 102-364, eff. 1-1-22; 102-650, eff. 8-27-21; 102-813, eff. 5-13-22; 102-1037, eff. 6-2-22.)

ARTICLE 85.

Section 85-5. The Illinois Act on the Aging is amended by changing Sections 4.02 and 4.06 as follows:

(20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

Sec. 4.02. Community Care Program. The Department shall establish a program of services to prevent unnecessary institutionalization of persons age 60 and older in need of long term care or who are established as persons who suffer from Alzheimer's disease or a related disorder under the Alzheimer's Disease Assistance Act, thereby enabling them to remain in their own homes or in other living arrangements.

Such preventive services, which may be coordinated with other programs for the aged and monitored by area agencies on aging in cooperation with the Department, may include, but are not limited to, any or all of the following:

(a) (blank);

(b) (blank);

(c) home care aide services;

(d) personal assistant services;

(e) adult day services;

(f) home-delivered meals;

(g) education in self-care;

(h) personal care services;

(i) adult day health services;

(j) habilitation services;

(k) respite care;

(k-5) community reintegration services;

(k-6) flexible senior services;

(k-7) medication management;

(k-8) emergency home response;

(l) other nonmedical social services that may enable the person to become self-supporting; or

(m) clearinghouse for information provided by senior citizen home owners who want to rent rooms to or share living space with other senior citizens.

The Department shall establish eligibility standards for such services. In determining the amount and nature of

services for which a person may qualify, consideration shall not be given to the value of cash, property or other assets held in the name of the person's spouse pursuant to a written agreement dividing marital property into equal but separate shares or pursuant to a transfer of the person's interest in a home to his spouse, provided that the spouse's share of the marital property is not made available to the person seeking such services.

Beginning January 1, 2008, the Department shall require as a condition of eligibility that all new financially eligible applicants apply for and enroll in medical assistance under Article V of the Illinois Public Aid Code in accordance with rules promulgated by the Department.

The Department shall, in conjunction with the Department of Public Aid (now Department of Healthcare and Family Services), seek appropriate amendments under Sections 1915 and 1924 of the Social Security Act. The purpose of the amendments shall be to extend eligibility for home and community based services under Sections 1915 and 1924 of the Social Security Act to persons who transfer to or for the benefit of a spouse those amounts of income and resources allowed under Section 1924 of the Social Security Act. Subject to the approval of such amendments, the Department shall extend the provisions of Section 5-4 of the Illinois Public Aid Code to persons who, but for the provision of home or community-based services, would require the level of care provided in an institution, as is

provided for in federal law. Those persons no longer found to be eligible for receiving noninstitutional services due to changes in the eligibility criteria shall be given 45 days notice prior to actual termination. Those persons receiving notice of termination may contact the Department and request the determination be appealed at any time during the 45 day notice period. The target population identified for the purposes of this Section are persons age 60 and older with an identified service need. Priority shall be given to those who are at imminent risk of institutionalization. The services shall be provided to eligible persons age 60 and older to the extent that the cost of the services together with the other personal maintenance expenses of the persons are reasonably related to the standards established for care in a group facility appropriate to the person's condition. These non-institutional services, pilot projects or experimental facilities may be provided as part of or in addition to those authorized by federal law or those funded and administered by the Department of Human Services. The Departments of Human Services, Healthcare and Family Services, Public Health, Veterans' Affairs, and Commerce and Economic Opportunity and other appropriate agencies of State, federal and local governments shall cooperate with the Department on Aging in the establishment and development of the non-institutional services. The Department shall require an annual audit from all personal assistant and home care aide vendors contracting

with the Department under this Section. The annual audit shall assure that each audited vendor's procedures are in compliance with Department's financial reporting guidelines requiring an administrative and employee wage and benefits cost split as defined in administrative rules. The audit is a public record under the Freedom of Information Act. The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department of Healthcare and Family Services, to effect the following: (1) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (2) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped. On and after July 1, 1996, all nursing home prescreenings for individuals 60 years of age or older shall be conducted by the Department.

As part of the Department on Aging's routine training of case managers and case manager supervisors, the Department may include information on family futures planning for persons who are age 60 or older and who are caregivers of their adult children with developmental disabilities. The content of the training shall be at the Department's discretion.

The Department is authorized to establish a system of recipient copayment for services provided under this Section, such copayment to be based upon the recipient's ability to pay

but in no case to exceed the actual cost of the services provided. Additionally, any portion of a person's income which is equal to or less than the federal poverty standard shall not be considered by the Department in determining the copayment. The level of such copayment shall be adjusted whenever necessary to reflect any change in the officially designated federal poverty standard.

The Department, or the Department's authorized representative, may recover the amount of moneys expended for services provided to or in behalf of a person under this Section by a claim against the person's estate or against the estate of the person's surviving spouse, but no recovery may be had until after the death of the surviving spouse, if any, and then only at such time when there is no surviving child who is under age 21 or blind or who has a permanent and total disability. This paragraph, however, shall not bar recovery, at the death of the person, of moneys for services provided to the person or in behalf of the person under this Section to which the person was not entitled; provided that such recovery shall not be enforced against any real estate while it is occupied as a homestead by the surviving spouse or other dependent, if no claims by other creditors have been filed against the estate, or, if such claims have been filed, they remain dormant for failure of prosecution or failure of the claimant to compel administration of the estate for the purpose of payment. This paragraph shall not bar recovery from

the estate of a spouse, under Sections 1915 and 1924 of the Social Security Act and Section 5-4 of the Illinois Public Aid Code, who precedes a person receiving services under this Section in death. All moneys for services paid to or in behalf of the person under this Section shall be claimed for recovery from the deceased spouse's estate. "Homestead", as used in this paragraph, means the dwelling house and contiguous real estate occupied by a surviving spouse or relative, as defined by the rules and regulations of the Department of Healthcare and Family Services, regardless of the value of the property.

The Department shall increase the effectiveness of the existing Community Care Program by:

(1) ensuring that in-home services included in the care plan are available on evenings and weekends;

(2) ensuring that care plans contain the services that eligible participants need based on the number of days in a month, not limited to specific blocks of time, as identified by the comprehensive assessment tool selected by the Department for use statewide, not to exceed the total monthly service cost maximum allowed for each service; the Department shall develop administrative rules to implement this item (2);

(3) ensuring that the participants have the right to choose the services contained in their care plan and to direct how those services are provided, based on administrative rules established by the Department;

(4) ensuring that the determination of need tool is accurate in determining the participants' level of need; to achieve this, the Department, in conjunction with the Older Adult Services Advisory Committee, shall institute a study of the relationship between the Determination of Need scores, level of need, service cost maximums, and the development and utilization of service plans no later than May 1, 2008; findings and recommendations shall be presented to the Governor and the General Assembly no later than January 1, 2009; recommendations shall include all needed changes to the service cost maximums schedule and additional covered services;

(5) ensuring that homemakers can provide personal care services that may or may not involve contact with clients, including but not limited to:

(A) bathing;

(B) grooming;

(C) toileting;

(D) nail care;

(E) transferring;

(F) respiratory services;

(G) exercise; or

(H) positioning;

(6) ensuring that homemaker program vendors are not restricted from hiring homemakers who are family members of clients or recommended by clients; the Department may

not, by rule or policy, require homemakers who are family members of clients or recommended by clients to accept assignments in homes other than the client;

(7) ensuring that the State may access maximum federal matching funds by seeking approval for the Centers for Medicare and Medicaid Services for modifications to the State's home and community based services waiver and additional waiver opportunities, including applying for enrollment in the Balance Incentive Payment Program by May 1, 2013, in order to maximize federal matching funds; this shall include, but not be limited to, modification that reflects all changes in the Community Care Program services and all increases in the services cost maximum;

(8) ensuring that the determination of need tool accurately reflects the service needs of individuals with Alzheimer's disease and related dementia disorders;

(9) ensuring that services are authorized accurately and consistently for the Community Care Program (CCP); the Department shall implement a Service Authorization policy directive; the purpose shall be to ensure that eligibility and services are authorized accurately and consistently in the CCP program; the policy directive shall clarify service authorization guidelines to Care Coordination Units and Community Care Program providers no later than May 1, 2013;

(10) working in conjunction with Care Coordination

Units, the Department of Healthcare and Family Services, the Department of Human Services, Community Care Program providers, and other stakeholders to make improvements to the Medicaid claiming processes and the Medicaid enrollment procedures or requirements as needed, including, but not limited to, specific policy changes or rules to improve the up-front enrollment of participants in the Medicaid program and specific policy changes or rules to insure more prompt submission of bills to the federal government to secure maximum federal matching dollars as promptly as possible; the Department on Aging shall have at least 3 meetings with stakeholders by January 1, 2014 in order to address these improvements;

(11) requiring home care service providers to comply with the rounding of hours worked provisions under the federal Fair Labor Standards Act (FLSA) and as set forth in 29 CFR 785.48(b) by May 1, 2013;

(12) implementing any necessary policy changes or promulgating any rules, no later than January 1, 2014, to assist the Department of Healthcare and Family Services in moving as many participants as possible, consistent with federal regulations, into coordinated care plans if a care coordination plan that covers long term care is available in the recipient's area; and

(13) maintaining fiscal year 2014 rates at the same level established on January 1, 2013.

By January 1, 2009 or as soon after the end of the Cash and Counseling Demonstration Project as is practicable, the Department may, based on its evaluation of the demonstration project, promulgate rules concerning personal assistant services, to include, but need not be limited to, qualifications, employment screening, rights under fair labor standards, training, fiduciary agent, and supervision requirements. All applicants shall be subject to the provisions of the Health Care Worker Background Check Act.

The Department shall develop procedures to enhance availability of services on evenings, weekends, and on an emergency basis to meet the respite needs of caregivers. Procedures shall be developed to permit the utilization of services in successive blocks of 24 hours up to the monthly maximum established by the Department. Workers providing these services shall be appropriately trained.

Beginning on the effective date of this amendatory Act of 1991, no person may perform chore/housekeeping and home care aide services under a program authorized by this Section unless that person has been issued a certificate of pre-service to do so by his or her employing agency. Information gathered to effect such certification shall include (i) the person's name, (ii) the date the person was hired by his or her current employer, and (iii) the training, including dates and levels. Persons engaged in the program authorized by this Section before the effective date of this

amendatory Act of 1991 shall be issued a certificate of all pre- and in-service training from his or her employer upon submitting the necessary information. The employing agency shall be required to retain records of all staff pre- and in-service training, and shall provide such records to the Department upon request and upon termination of the employer's contract with the Department. In addition, the employing agency is responsible for the issuance of certifications of in-service training completed to their employees.

The Department is required to develop a system to ensure that persons working as home care aides and personal assistants receive increases in their wages when the federal minimum wage is increased by requiring vendors to certify that they are meeting the federal minimum wage statute for home care aides and personal assistants. An employer that cannot ensure that the minimum wage increase is being given to home care aides and personal assistants shall be denied any increase in reimbursement costs.

The Community Care Program Advisory Committee is created in the Department on Aging. The Director shall appoint individuals to serve in the Committee, who shall serve at their own expense. Members of the Committee must abide by all applicable ethics laws. The Committee shall advise the Department on issues related to the Department's program of services to prevent unnecessary institutionalization. The Committee shall meet on a bi-monthly basis and shall serve to

identify and advise the Department on present and potential issues affecting the service delivery network, the program's clients, and the Department and to recommend solution strategies. Persons appointed to the Committee shall be appointed on, but not limited to, their own and their agency's experience with the program, geographic representation, and willingness to serve. The Director shall appoint members to the Committee to represent provider, advocacy, policy research, and other constituencies committed to the delivery of high quality home and community-based services to older adults. Representatives shall be appointed to ensure representation from community care providers including, but not limited to, adult day service providers, homemaker providers, case coordination and case management units, emergency home response providers, statewide trade or labor unions that represent home care aides and direct care staff, area agencies on aging, adults over age 60, membership organizations representing older adults, and other organizational entities, providers of care, or individuals with demonstrated interest and expertise in the field of home and community care as determined by the Director.

Nominations may be presented from any agency or State association with interest in the program. The Director, or his or her designee, shall serve as the permanent co-chair of the advisory committee. One other co-chair shall be nominated and approved by the members of the committee on an annual basis.

Committee members' terms of appointment shall be for 4 years with one-quarter of the appointees' terms expiring each year. A member shall continue to serve until his or her replacement is named. The Department shall fill vacancies that have a remaining term of over one year, and this replacement shall occur through the annual replacement of expiring terms. The Director shall designate Department staff to provide technical assistance and staff support to the committee. Department representation shall not constitute membership of the committee. All Committee papers, issues, recommendations, reports, and meeting memoranda are advisory only. The Director, or his or her designee, shall make a written report, as requested by the Committee, regarding issues before the Committee.

The Department on Aging and the Department of Human Services shall cooperate in the development and submission of an annual report on programs and services provided under this Section. Such joint report shall be filed with the Governor and the General Assembly on or before March 31 ~~September 30~~ each year.

The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

Those persons previously found eligible for receiving non-institutional services whose services were discontinued under the Emergency Budget Act of Fiscal Year 1992, and who do not meet the eligibility standards in effect on or after July 1, 1992, shall remain ineligible on and after July 1, 1992. Those persons previously not required to cost-share and who were required to cost-share effective March 1, 1992, shall continue to meet cost-share requirements on and after July 1, 1992. Beginning July 1, 1992, all clients will be required to meet eligibility, cost-share, and other requirements and will have services discontinued or altered when they fail to meet these requirements.

For the purposes of this Section, "flexible senior services" refers to services that require one-time or periodic expenditures including, but not limited to, respite care, home modification, assistive technology, housing assistance, and transportation.

The Department shall implement an electronic service verification based on global positioning systems or other cost-effective technology for the Community Care Program no later than January 1, 2014.

The Department shall require, as a condition of eligibility, enrollment in the medical assistance program under Article V of the Illinois Public Aid Code (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting

requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.

The Department shall delay Community Care Program services until an applicant is determined eligible for medical assistance under Article V of the Illinois Public Aid Code (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.

The Department shall implement co-payments for the Community Care Program at the federally allowable maximum level (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.

The Department shall continue to provide other Community

Care Program reports as required by statute.

The Department shall conduct a quarterly review of Care Coordination Unit performance and adherence to service guidelines. The quarterly review shall be reported to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate. The Department shall collect and report longitudinal data on the performance of each care coordination unit. Nothing in this paragraph shall be construed to require the Department to identify specific care coordination units.

In regard to community care providers, failure to comply with Department on Aging policies shall be cause for disciplinary action, including, but not limited to, disqualification from serving Community Care Program clients. Each provider, upon submission of any bill or invoice to the Department for payment for services rendered, shall include a notarized statement, under penalty of perjury pursuant to Section 1-109 of the Code of Civil Procedure, that the provider has complied with all Department policies.

The Director of the Department on Aging shall make information available to the State Board of Elections as may be required by an agreement the State Board of Elections has entered into with a multi-state voter registration list maintenance system.

Within 30 days after July 6, 2017 (the effective date of

Public Act 100-23), rates shall be increased to $18.29 per hour, for the purpose of increasing, by at least $.72 per hour, the wages paid by those vendors to their employees who provide homemaker services. The Department shall pay an enhanced rate under the Community Care Program to those in-home service provider agencies that offer health insurance coverage as a benefit to their direct service worker employees consistent with the mandates of Public Act 95-713. For State fiscal years 2018 and 2019, the enhanced rate shall be $1.77 per hour. The rate shall be adjusted using actuarial analysis based on the cost of care, but shall not be set below $1.77 per hour. The Department shall adopt rules, including emergency rules under subsections (y) and (bb) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this paragraph.

Subject to federal approval, beginning on January 1, 2024, rates for adult day services shall be increased to $16.84 per hour and rates for each way transportation services for adult day services shall be increased to $12.44 per unit transportation.

The General Assembly finds it necessary to authorize an aggressive Medicaid enrollment initiative designed to maximize federal Medicaid funding for the Community Care Program which produces significant savings for the State of Illinois. The Department on Aging shall establish and implement a Community Care Program Medicaid Initiative. Under the Initiative, the

Department on Aging shall, at a minimum: (i) provide an enhanced rate to adequately compensate care coordination units to enroll eligible Community Care Program clients into Medicaid; (ii) use recommendations from a stakeholder committee on how best to implement the Initiative; and (iii) establish requirements for State agencies to make enrollment in the State's Medical Assistance program easier for seniors.

The Community Care Program Medicaid Enrollment Oversight Subcommittee is created as a subcommittee of the Older Adult Services Advisory Committee established in Section 35 of the Older Adult Services Act to make recommendations on how best to increase the number of medical assistance recipients who are enrolled in the Community Care Program. The Subcommittee shall consist of all of the following persons who must be appointed within 30 days after the effective date of this amendatory Act of the 100th General Assembly:

(1) The Director of Aging, or his or her designee, who shall serve as the chairperson of the Subcommittee.

(2) One representative of the Department of Healthcare and Family Services, appointed by the Director of Healthcare and Family Services.

(3) One representative of the Department of Human Services, appointed by the Secretary of Human Services.

(4) One individual representing a care coordination unit, appointed by the Director of Aging.

(5) One individual from a non-governmental statewide

organization that advocates for seniors, appointed by the Director of Aging.

(6) One individual representing Area Agencies on Aging, appointed by the Director of Aging.

(7) One individual from a statewide association dedicated to Alzheimer's care, support, and research, appointed by the Director of Aging.

(8) One individual from an organization that employs persons who provide services under the Community Care Program, appointed by the Director of Aging.

(9) One member of a trade or labor union representing persons who provide services under the Community Care Program, appointed by the Director of Aging.

(10) One member of the Senate, who shall serve as co-chairperson, appointed by the President of the Senate.

(11) One member of the Senate, who shall serve as co-chairperson, appointed by the Minority Leader of the Senate.

(12) One member of the House of Representatives, who shall serve as co-chairperson, appointed by the Speaker of the House of Representatives.

(13) One member of the House of Representatives, who shall serve as co-chairperson, appointed by the Minority Leader of the House of Representatives.

(14) One individual appointed by a labor organization representing frontline employees at the Department of

Human Services.

The Subcommittee shall provide oversight to the Community Care Program Medicaid Initiative and shall meet quarterly. At each Subcommittee meeting the Department on Aging shall provide the following data sets to the Subcommittee: (A) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program and are enrolled in the State's Medical Assistance Program; (B) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program, but are not enrolled in the State's Medical Assistance Program; and (C) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program and are eligible for benefits under the State's Medical Assistance Program, but are not enrolled in the State's Medical Assistance Program. In addition to this data, the Department on Aging shall provide the Subcommittee with plans on how the Department on Aging will reduce the number of Illinois residents who are not enrolled in the State's Medical Assistance Program but who are eligible for medical assistance benefits. The Department on Aging shall enroll in the State's Medical Assistance Program those Illinois residents who receive services under the Community Care Program and are eligible for medical assistance benefits but are not enrolled in the State's Medicaid Assistance Program. The data provided

to the Subcommittee shall be made available to the public via the Department on Aging's website.

The Department on Aging, with the involvement of the Subcommittee, shall collaborate with the Department of Human Services and the Department of Healthcare and Family Services on how best to achieve the responsibilities of the Community Care Program Medicaid Initiative.

The Department on Aging, the Department of Human Services, and the Department of Healthcare and Family Services shall coordinate and implement a streamlined process for seniors to access benefits under the State's Medical Assistance Program.

The Subcommittee shall collaborate with the Department of Human Services on the adoption of a uniform application submission process. The Department of Human Services and any other State agency involved with processing the medical assistance application of any person enrolled in the Community Care Program shall include the appropriate care coordination unit in all communications related to the determination or status of the application.

The Community Care Program Medicaid Initiative shall provide targeted funding to care coordination units to help seniors complete their applications for medical assistance benefits. On and after July 1, 2019, care coordination units shall receive no less than $200 per completed application, which rate may be included in a bundled rate for initial intake services when Medicaid application assistance is provided in

conjunction with the initial intake process for new program participants.

The Community Care Program Medicaid Initiative shall cease operation 5 years after the effective date of this amendatory Act of the 100th General Assembly, after which the Subcommittee shall dissolve.

(Source: P.A. 101-10, eff. 6-5-19; 102-1071, eff. 6-10-22.)

(20 ILCS 105/4.06)

Sec. 4.06. Coordinated services for minority senior citizens ~~Minority Senior Citizen Program~~. The Department shall develop strategies ~~a program~~ to identify the special needs and problems of minority senior citizens and evaluate the adequacy and accessibility of existing services ~~programs~~ and information for minority senior citizens. The Department shall coordinate services for minority senior citizens through the Department of Public Health, the Department of Healthcare and Family Services, and the Department of Human Services.

The Department shall develop procedures to enhance and identify availability of services and shall promulgate administrative rules to establish the responsibilities of the Department.

The Department on Aging, the Department of Public Health, the Department of Healthcare and Family Services, and the Department of Human Services shall cooperate in the development and submission of an annual report on ~~programs and~~

services provided under this Section. The joint report shall be filed with the Governor and the General Assembly on or before September 30 of each year.

(Source: P.A. 95-331, eff. 8-21-07.)

ARTICLE 90.

Section 90-5. The Illinois Act on the Aging is amended by changing Sections 4.02 and 4.07 as follows:

(20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

Sec. 4.02. Community Care Program. The Department shall establish a program of services to prevent unnecessary institutionalization of persons age 60 and older in need of long term care or who are established as persons who suffer from Alzheimer's disease or a related disorder under the Alzheimer's Disease Assistance Act, thereby enabling them to remain in their own homes or in other living arrangements. Such preventive services, which may be coordinated with other programs for the aged and monitored by area agencies on aging in cooperation with the Department, may include, but are not limited to, any or all of the following:

(a) (blank);

(b) (blank);

(c) home care aide services;

(d) personal assistant services;

(e) adult day services;

(f) home-delivered meals;

(g) education in self-care;

(h) personal care services;

(i) adult day health services;

(j) habilitation services;

(k) respite care;

(k-5) community reintegration services;

(k-6) flexible senior services;

(k-7) medication management;

(k-8) emergency home response;

(l) other nonmedical social services that may enable the person to become self-supporting; or

(m) clearinghouse for information provided by senior citizen home owners who want to rent rooms to or share living space with other senior citizens.

The Department shall establish eligibility standards for such services. In determining the amount and nature of services for which a person may qualify, consideration shall not be given to the value of cash, property or other assets held in the name of the person's spouse pursuant to a written agreement dividing marital property into equal but separate shares or pursuant to a transfer of the person's interest in a home to his spouse, provided that the spouse's share of the marital property is not made available to the person seeking such services.

Beginning January 1, 2008, the Department shall require as a condition of eligibility that all new financially eligible applicants apply for and enroll in medical assistance under Article V of the Illinois Public Aid Code in accordance with rules promulgated by the Department.

The Department shall, in conjunction with the Department of Public Aid (now Department of Healthcare and Family Services), seek appropriate amendments under Sections 1915 and 1924 of the Social Security Act. The purpose of the amendments shall be to extend eligibility for home and community based services under Sections 1915 and 1924 of the Social Security Act to persons who transfer to or for the benefit of a spouse those amounts of income and resources allowed under Section 1924 of the Social Security Act. Subject to the approval of such amendments, the Department shall extend the provisions of Section 5-4 of the Illinois Public Aid Code to persons who, but for the provision of home or community-based services, would require the level of care provided in an institution, as is provided for in federal law. Those persons no longer found to be eligible for receiving noninstitutional services due to changes in the eligibility criteria shall be given 45 days notice prior to actual termination. Those persons receiving notice of termination may contact the Department and request the determination be appealed at any time during the 45 day notice period. The target population identified for the purposes of this Section are persons age 60 and older with an

identified service need. Priority shall be given to those who are at imminent risk of institutionalization. The services shall be provided to eligible persons age 60 and older to the extent that the cost of the services together with the other personal maintenance expenses of the persons are reasonably related to the standards established for care in a group facility appropriate to the person's condition. These non-institutional services, pilot projects or experimental facilities may be provided as part of or in addition to those authorized by federal law or those funded and administered by the Department of Human Services. The Departments of Human Services, Healthcare and Family Services, Public Health, Veterans' Affairs, and Commerce and Economic Opportunity and other appropriate agencies of State, federal and local governments shall cooperate with the Department on Aging in the establishment and development of the non-institutional services. The Department shall require an annual audit from all personal assistant and home care aide vendors contracting with the Department under this Section. The annual audit shall assure that each audited vendor's procedures are in compliance with Department's financial reporting guidelines requiring an administrative and employee wage and benefits cost split as defined in administrative rules. The audit is a public record under the Freedom of Information Act. The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human

Services and the Department of Healthcare and Family Services, to effect the following: (1) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (2) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped. On and after July 1, 1996, all nursing home prescreenings for individuals 60 years of age or older shall be conducted by the Department.

As part of the Department on Aging's routine training of case managers and case manager supervisors, the Department may include information on family futures planning for persons who are age 60 or older and who are caregivers of their adult children with developmental disabilities. The content of the training shall be at the Department's discretion.

The Department is authorized to establish a system of recipient copayment for services provided under this Section, such copayment to be based upon the recipient's ability to pay but in no case to exceed the actual cost of the services provided. Additionally, any portion of a person's income which is equal to or less than the federal poverty standard shall not be considered by the Department in determining the copayment. The level of such copayment shall be adjusted whenever necessary to reflect any change in the officially designated federal poverty standard.

The Department, or the Department's authorized

representative, may recover the amount of moneys expended for services provided to or in behalf of a person under this Section by a claim against the person's estate or against the estate of the person's surviving spouse, but no recovery may be had until after the death of the surviving spouse, if any, and then only at such time when there is no surviving child who is under age 21 or blind or who has a permanent and total disability. This paragraph, however, shall not bar recovery, at the death of the person, of moneys for services provided to the person or in behalf of the person under this Section to which the person was not entitled; provided that such recovery shall not be enforced against any real estate while it is occupied as a homestead by the surviving spouse or other dependent, if no claims by other creditors have been filed against the estate, or, if such claims have been filed, they remain dormant for failure of prosecution or failure of the claimant to compel administration of the estate for the purpose of payment. This paragraph shall not bar recovery from the estate of a spouse, under Sections 1915 and 1924 of the Social Security Act and Section 5-4 of the Illinois Public Aid Code, who precedes a person receiving services under this Section in death. All moneys for services paid to or in behalf of the person under this Section shall be claimed for recovery from the deceased spouse's estate. "Homestead", as used in this paragraph, means the dwelling house and contiguous real estate occupied by a surviving spouse or relative, as defined

by the rules and regulations of the Department of Healthcare and Family Services, regardless of the value of the property.

The Department shall increase the effectiveness of the existing Community Care Program by:

(1) ensuring that in-home services included in the care plan are available on evenings and weekends;

(2) ensuring that care plans contain the services that eligible participants need based on the number of days in a month, not limited to specific blocks of time, as identified by the comprehensive assessment tool selected by the Department for use statewide, not to exceed the total monthly service cost maximum allowed for each service; the Department shall develop administrative rules to implement this item (2);

(3) ensuring that the participants have the right to choose the services contained in their care plan and to direct how those services are provided, based on administrative rules established by the Department;

(4) ensuring that the determination of need tool is accurate in determining the participants' level of need; to achieve this, the Department, in conjunction with the Older Adult Services Advisory Committee, shall institute a study of the relationship between the Determination of Need scores, level of need, service cost maximums, and the development and utilization of service plans no later than May 1, 2008; findings and recommendations shall be

presented to the Governor and the General Assembly no later than January 1, 2009; recommendations shall include all needed changes to the service cost maximums schedule and additional covered services;

(5) ensuring that homemakers can provide personal care services that may or may not involve contact with clients, including but not limited to:

(A) bathing;

(B) grooming;

(C) toileting;

(D) nail care;

(E) transferring;

(F) respiratory services;

(G) exercise; or

(H) positioning;

(6) ensuring that homemaker program vendors are not restricted from hiring homemakers who are family members of clients or recommended by clients; the Department may not, by rule or policy, require homemakers who are family members of clients or recommended by clients to accept assignments in homes other than the client;

(7) ensuring that the State may access maximum federal matching funds by seeking approval for the Centers for Medicare and Medicaid Services for modifications to the State's home and community based services waiver and additional waiver opportunities, including applying for

enrollment in the Balance Incentive Payment Program by May 1, 2013, in order to maximize federal matching funds; this shall include, but not be limited to, modification that reflects all changes in the Community Care Program services and all increases in the services cost maximum;

(8) ensuring that the determination of need tool accurately reflects the service needs of individuals with Alzheimer's disease and related dementia disorders;

(9) ensuring that services are authorized accurately and consistently for the Community Care Program (CCP); the Department shall implement a Service Authorization policy directive; the purpose shall be to ensure that eligibility and services are authorized accurately and consistently in the CCP program; the policy directive shall clarify service authorization guidelines to Care Coordination Units and Community Care Program providers no later than May 1, 2013;

(10) working in conjunction with Care Coordination Units, the Department of Healthcare and Family Services, the Department of Human Services, Community Care Program providers, and other stakeholders to make improvements to the Medicaid claiming processes and the Medicaid enrollment procedures or requirements as needed, including, but not limited to, specific policy changes or rules to improve the up-front enrollment of participants in the Medicaid program and specific policy changes or

rules to insure more prompt submission of bills to the federal government to secure maximum federal matching dollars as promptly as possible; the Department on Aging shall have at least 3 meetings with stakeholders by January 1, 2014 in order to address these improvements;

(11) requiring home care service providers to comply with the rounding of hours worked provisions under the federal Fair Labor Standards Act (FLSA) and as set forth in 29 CFR 785.48(b) by May 1, 2013;

(12) implementing any necessary policy changes or promulgating any rules, no later than January 1, 2014, to assist the Department of Healthcare and Family Services in moving as many participants as possible, consistent with federal regulations, into coordinated care plans if a care coordination plan that covers long term care is available in the recipient's area; and

(13) maintaining fiscal year 2014 rates at the same level established on January 1, 2013.

By January 1, 2009 or as soon after the end of the Cash and Counseling Demonstration Project as is practicable, the Department may, based on its evaluation of the demonstration project, promulgate rules concerning personal assistant services, to include, but need not be limited to, qualifications, employment screening, rights under fair labor standards, training, fiduciary agent, and supervision requirements. All applicants shall be subject to the

provisions of the Health Care Worker Background Check Act.

The Department shall develop procedures to enhance availability of services on evenings, weekends, and on an emergency basis to meet the respite needs of caregivers. Procedures shall be developed to permit the utilization of services in successive blocks of 24 hours up to the monthly maximum established by the Department. Workers providing these services shall be appropriately trained.

Beginning on the effective date of this amendatory Act of 1991, no person may perform chore/housekeeping and home care aide services under a program authorized by this Section unless that person has been issued a certificate of pre-service to do so by his or her employing agency. Information gathered to effect such certification shall include (i) the person's name, (ii) the date the person was hired by his or her current employer, and (iii) the training, including dates and levels. Persons engaged in the program authorized by this Section before the effective date of this amendatory Act of 1991 shall be issued a certificate of all pre- and in-service training from his or her employer upon submitting the necessary information. The employing agency shall be required to retain records of all staff pre- and in-service training, and shall provide such records to the Department upon request and upon termination of the employer's contract with the Department. In addition, the employing agency is responsible for the issuance of certifications of

in-service training completed to their employees.

The Department is required to develop a system to ensure that persons working as home care aides and personal assistants receive increases in their wages when the federal minimum wage is increased by requiring vendors to certify that they are meeting the federal minimum wage statute for home care aides and personal assistants. An employer that cannot ensure that the minimum wage increase is being given to home care aides and personal assistants shall be denied any increase in reimbursement costs.

The Community Care Program Advisory Committee is created in the Department on Aging. The Director shall appoint individuals to serve in the Committee, who shall serve at their own expense. Members of the Committee must abide by all applicable ethics laws. The Committee shall advise the Department on issues related to the Department's program of services to prevent unnecessary institutionalization. The Committee shall meet on a bi-monthly basis and shall serve to identify and advise the Department on present and potential issues affecting the service delivery network, the program's clients, and the Department and to recommend solution strategies. Persons appointed to the Committee shall be appointed on, but not limited to, their own and their agency's experience with the program, geographic representation, and willingness to serve. The Director shall appoint members to the Committee to represent provider, advocacy, policy

research, and other constituencies committed to the delivery of high quality home and community-based services to older adults. Representatives shall be appointed to ensure representation from community care providers including, but not limited to, adult day service providers, homemaker providers, case coordination and case management units, emergency home response providers, statewide trade or labor unions that represent home care aides and direct care staff, area agencies on aging, adults over age 60, membership organizations representing older adults, and other organizational entities, providers of care, or individuals with demonstrated interest and expertise in the field of home and community care as determined by the Director.

Nominations may be presented from any agency or State association with interest in the program. The Director, or his or her designee, shall serve as the permanent co-chair of the advisory committee. One other co-chair shall be nominated and approved by the members of the committee on an annual basis. Committee members' terms of appointment shall be for 4 years with one-quarter of the appointees' terms expiring each year. A member shall continue to serve until his or her replacement is named. The Department shall fill vacancies that have a remaining term of over one year, and this replacement shall occur through the annual replacement of expiring terms. The Director shall designate Department staff to provide technical assistance and staff support to the committee. Department

representation shall not constitute membership of the committee. All Committee papers, issues, recommendations, reports, and meeting memoranda are advisory only. The Director, or his or her designee, shall make a written report, as requested by the Committee, regarding issues before the Committee.

The Department on Aging and the Department of Human Services shall cooperate in the development and submission of an annual report on programs and services provided under this Section. Such joint report shall be filed with the Governor and the General Assembly on or before March 31 of the following fiscal year ~~September 30 each year~~.

The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

Those persons previously found eligible for receiving non-institutional services whose services were discontinued under the Emergency Budget Act of Fiscal Year 1992, and who do not meet the eligibility standards in effect on or after July 1, 1992, shall remain ineligible on and after July 1, 1992. Those persons previously not required to cost-share and who were required to cost-share effective March 1, 1992, shall continue to meet cost-share requirements on and after July 1,

1992. Beginning July 1, 1992, all clients will be required to meet eligibility, cost-share, and other requirements and will have services discontinued or altered when they fail to meet these requirements.

For the purposes of this Section, "flexible senior services" refers to services that require one-time or periodic expenditures including, but not limited to, respite care, home modification, assistive technology, housing assistance, and transportation.

The Department shall implement an electronic service verification based on global positioning systems or other cost-effective technology for the Community Care Program no later than January 1, 2014.

The Department shall require, as a condition of eligibility, enrollment in the medical assistance program under Article V of the Illinois Public Aid Code (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.

The Department shall delay Community Care Program services until an applicant is determined eligible for medical assistance under Article V of the Illinois Public Aid Code (i)

beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.

The Department shall implement co-payments for the Community Care Program at the federally allowable maximum level (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.

The Department shall continue to provide other Community Care Program reports as required by statute.

The Department shall conduct a quarterly review of Care Coordination Unit performance and adherence to service guidelines. The quarterly review shall be reported to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate. The Department shall collect and report longitudinal data on the performance of

each care coordination unit. Nothing in this paragraph shall be construed to require the Department to identify specific care coordination units.

In regard to community care providers, failure to comply with Department on Aging policies shall be cause for disciplinary action, including, but not limited to, disqualification from serving Community Care Program clients. Each provider, upon submission of any bill or invoice to the Department for payment for services rendered, shall include a notarized statement, under penalty of perjury pursuant to Section 1-109 of the Code of Civil Procedure, that the provider has complied with all Department policies.

The Director of the Department on Aging shall make information available to the State Board of Elections as may be required by an agreement the State Board of Elections has entered into with a multi-state voter registration list maintenance system.

Within 30 days after July 6, 2017 (the effective date of Public Act 100-23), rates shall be increased to $18.29 per hour, for the purpose of increasing, by at least $.72 per hour, the wages paid by those vendors to their employees who provide homemaker services. The Department shall pay an enhanced rate under the Community Care Program to those in-home service provider agencies that offer health insurance coverage as a benefit to their direct service worker employees consistent with the mandates of Public Act 95-713. For State fiscal years

2018 and 2019, the enhanced rate shall be $1.77 per hour. The rate shall be adjusted using actuarial analysis based on the cost of care, but shall not be set below $1.77 per hour. The Department shall adopt rules, including emergency rules under subsections (y) and (bb) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this paragraph.

The General Assembly finds it necessary to authorize an aggressive Medicaid enrollment initiative designed to maximize federal Medicaid funding for the Community Care Program which produces significant savings for the State of Illinois. The Department on Aging shall establish and implement a Community Care Program Medicaid Initiative. Under the Initiative, the Department on Aging shall, at a minimum: (i) provide an enhanced rate to adequately compensate care coordination units to enroll eligible Community Care Program clients into Medicaid; (ii) use recommendations from a stakeholder committee on how best to implement the Initiative; and (iii) establish requirements for State agencies to make enrollment in the State's Medical Assistance program easier for seniors.

The Community Care Program Medicaid Enrollment Oversight Subcommittee is created as a subcommittee of the Older Adult Services Advisory Committee established in Section 35 of the Older Adult Services Act to make recommendations on how best to increase the number of medical assistance recipients who are enrolled in the Community Care Program. The Subcommittee

shall consist of all of the following persons who must be appointed within 30 days after the effective date of this amendatory Act of the 100th General Assembly:

(1) The Director of Aging, or his or her designee, who shall serve as the chairperson of the Subcommittee.

(2) One representative of the Department of Healthcare and Family Services, appointed by the Director of Healthcare and Family Services.

(3) One representative of the Department of Human Services, appointed by the Secretary of Human Services.

(4) One individual representing a care coordination unit, appointed by the Director of Aging.

(5) One individual from a non-governmental statewide organization that advocates for seniors, appointed by the Director of Aging.

(6) One individual representing Area Agencies on Aging, appointed by the Director of Aging.

(7) One individual from a statewide association dedicated to Alzheimer's care, support, and research, appointed by the Director of Aging.

(8) One individual from an organization that employs persons who provide services under the Community Care Program, appointed by the Director of Aging.

(9) One member of a trade or labor union representing persons who provide services under the Community Care Program, appointed by the Director of Aging.

(10) One member of the Senate, who shall serve as co-chairperson, appointed by the President of the Senate.

(11) One member of the Senate, who shall serve as co-chairperson, appointed by the Minority Leader of the Senate.

(12) One member of the House of Representatives, who shall serve as co-chairperson, appointed by the Speaker of the House of Representatives.

(13) One member of the House of Representatives, who shall serve as co-chairperson, appointed by the Minority Leader of the House of Representatives.

(14) One individual appointed by a labor organization representing frontline employees at the Department of Human Services.

The Subcommittee shall provide oversight to the Community Care Program Medicaid Initiative and shall meet quarterly. At each Subcommittee meeting the Department on Aging shall provide the following data sets to the Subcommittee: (A) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program and are enrolled in the State's Medical Assistance Program; (B) the number of Illinois residents, categorized by planning and service area, who are receiving services under the Community Care Program, but are not enrolled in the State's Medical Assistance Program; and (C) the number of Illinois residents, categorized by planning and

service area, who are receiving services under the Community Care Program and are eligible for benefits under the State's Medical Assistance Program, but are not enrolled in the State's Medical Assistance Program. In addition to this data, the Department on Aging shall provide the Subcommittee with plans on how the Department on Aging will reduce the number of Illinois residents who are not enrolled in the State's Medical Assistance Program but who are eligible for medical assistance benefits. The Department on Aging shall enroll in the State's Medical Assistance Program those Illinois residents who receive services under the Community Care Program and are eligible for medical assistance benefits but are not enrolled in the State's Medicaid Assistance Program. The data provided to the Subcommittee shall be made available to the public via the Department on Aging's website.

The Department on Aging, with the involvement of the Subcommittee, shall collaborate with the Department of Human Services and the Department of Healthcare and Family Services on how best to achieve the responsibilities of the Community Care Program Medicaid Initiative.

The Department on Aging, the Department of Human Services, and the Department of Healthcare and Family Services shall coordinate and implement a streamlined process for seniors to access benefits under the State's Medical Assistance Program.

The Subcommittee shall collaborate with the Department of Human Services on the adoption of a uniform application

submission process. The Department of Human Services and any other State agency involved with processing the medical assistance application of any person enrolled in the Community Care Program shall include the appropriate care coordination unit in all communications related to the determination or status of the application.

The Community Care Program Medicaid Initiative shall provide targeted funding to care coordination units to help seniors complete their applications for medical assistance benefits. On and after July 1, 2019, care coordination units shall receive no less than $200 per completed application, which rate may be included in a bundled rate for initial intake services when Medicaid application assistance is provided in conjunction with the initial intake process for new program participants.

The Community Care Program Medicaid Initiative shall cease operation 5 years after the effective date of this amendatory Act of the 100th General Assembly, after which the Subcommittee shall dissolve.

(Source: P.A. 101-10, eff. 6-5-19; 102-1071, eff. 6-10-22.)

(20 ILCS 105/4.07)

Sec. 4.07. Home-delivered meals.

(a) Every citizen of the State of Illinois who qualifies for home-delivered meals under the federal Older Americans Act shall be provided services, subject to appropriation. The

Department shall file a report with the General Assembly and the Illinois Council on Aging by March 31 of the following fiscal year ~~January 1 of each year~~. The report shall include, but not be limited to, the following information: (i) estimates, by county, of citizens denied service due to insufficient funds during the preceding fiscal year and the potential impact on service delivery of any additional funds appropriated for the current fiscal year; (ii) geographic areas and special populations unserved and underserved in the preceding fiscal year; (iii) estimates of additional funds needed to permit the full funding of the program and the statewide provision of services in the next fiscal year, including staffing and equipment needed to prepare and deliver meals; (iv) recommendations for increasing the amount of federal funding captured for the program; (v) recommendations for serving unserved and underserved areas and special populations, to include rural areas, dietetic meals, weekend meals, and 2 or more meals per day; and (vi) any other information needed to assist the General Assembly and the Illinois Council on Aging in developing a plan to address unserved and underserved areas of the State.

(b) Subject to appropriation, on an annual basis each recipient of home-delivered meals shall receive a fact sheet developed by the Department on Aging with a current list of toll-free numbers to access information on various health conditions, elder abuse, and programs for persons 60 years of

age and older. The fact sheet shall be written in a language that the client understands, if possible. In addition, each recipient of home-delivered meals shall receive updates on any new program for which persons 60 years of age and older may be eligible.

(Source: P.A. 102-253, eff. 8-6-21.)

Section 90-10. The Respite Program Act is amended by changing Section 12 as follows:

(320 ILCS 10/12) (from Ch. 23, par. 6212)

Sec. 12. Annual report. The Director shall submit a report by March 31 of the following fiscal year ~~each year~~ to the Governor and the General Assembly detailing the progress of the respite care services provided under this Act and shall also include an estimate of the demand for respite care services over the next 10 years.

(Source: P.A. 100-972, eff. 1-1-19.)

ARTICLE 95.

Section 95-5. The Hospital Licensing Act is amended by changing Section 6.09 as follows:

(210 ILCS 85/6.09) (from Ch. 111 1/2, par. 147.09)

Sec. 6.09. (a) In order to facilitate the orderly

transition of aged patients and patients with disabilities from hospitals to post-hospital care, whenever a patient who qualifies for the federal Medicare program is hospitalized, the patient shall be notified of discharge at least 24 hours prior to discharge from the hospital. With regard to pending discharges to a skilled nursing facility, the hospital must notify the case coordination unit, as defined in 89 Ill. Adm. Code 240.260, at least 24 hours prior to discharge. When the assessment is completed in the hospital, the case coordination unit shall provide a copy of the required assessment documentation directly to the nursing home to which the patient is being discharged prior to discharge. The Department on Aging shall provide notice of this requirement to case coordination units. When a case coordination unit is unable to complete an assessment in a hospital prior to the discharge of a patient, 60 years of age or older, to a nursing home, the case coordination unit shall notify the Department on Aging which shall notify the Department of Healthcare and Family Services. The ~~Department of Healthcare and Family Services and the~~ Department on Aging shall adopt rules to address these instances to ensure that the patient is able to access nursing home care, the nursing home is not penalized for accepting the admission, and the patient's timely discharge from the hospital is not delayed, to the extent permitted under federal law or regulation. Nothing in this subsection shall preclude federal requirements for a pre-admission screening/mental

health (PAS/MH) as required under Section 2-201.5 of the Nursing Home Care Act or State or federal law or regulation. If home health services are ordered, the hospital must inform its designated case coordination unit, as defined in 89 Ill. Adm. Code 240.260, of the pending discharge and must provide the patient with the case coordination unit's telephone number and other contact information.

(b) Every hospital shall develop procedures for a physician with medical staff privileges at the hospital or any appropriate medical staff member to provide the discharge notice prescribed in subsection (a) of this Section. The procedures must include prohibitions against discharging or referring a patient to any of the following if unlicensed, uncertified, or unregistered: (i) a board and care facility, as defined in the Board and Care Home Act; (ii) an assisted living and shared housing establishment, as defined in the Assisted Living and Shared Housing Act; (iii) a facility licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, the ID/DD Community Care Act, or the MC/DD Act; (iv) a supportive living facility, as defined in Section 5-5.01a of the Illinois Public Aid Code; or (v) a free-standing hospice facility licensed under the Hospice Program Licensing Act if licensure, certification, or registration is required. The Department of Public Health shall annually provide hospitals with a list of licensed, certified, or registered board and care facilities, assisted

living and shared housing establishments, nursing homes, supportive living facilities, facilities licensed under the ID/DD Community Care Act, the MC/DD Act, or the Specialized Mental Health Rehabilitation Act of 2013, and hospice facilities. Reliance upon this list by a hospital shall satisfy compliance with this requirement. The procedure may also include a waiver for any case in which a discharge notice is not feasible due to a short length of stay in the hospital by the patient, or for any case in which the patient voluntarily desires to leave the hospital before the expiration of the 24 hour period.

(c) At least 24 hours prior to discharge from the hospital, the patient shall receive written information on the patient's right to appeal the discharge pursuant to the federal Medicare program, including the steps to follow to appeal the discharge and the appropriate telephone number to call in case the patient intends to appeal the discharge.

(d) Before transfer of a patient to a long term care facility licensed under the Nursing Home Care Act where elderly persons reside, a hospital shall as soon as practicable initiate a name-based criminal history background check by electronic submission to the Illinois State Police for all persons between the ages of 18 and 70 years; provided, however, that a hospital shall be required to initiate such a background check only with respect to patients who:

(1) are transferring to a long term care facility for

the first time;

(2) have been in the hospital more than 5 days;

(3) are reasonably expected to remain at the long term care facility for more than 30 days;

(4) have a known history of serious mental illness or substance abuse; and

(5) are independently ambulatory or mobile for more than a temporary period of time.

A hospital may also request a criminal history background check for a patient who does not meet any of the criteria set forth in items (1) through (5).

A hospital shall notify a long term care facility if the hospital has initiated a criminal history background check on a patient being discharged to that facility. In all circumstances in which the hospital is required by this subsection to initiate the criminal history background check, the transfer to the long term care facility may proceed regardless of the availability of criminal history results. Upon receipt of the results, the hospital shall promptly forward the results to the appropriate long term care facility. If the results of the background check are inconclusive, the hospital shall have no additional duty or obligation to seek additional information from, or about, the patient.

(Source: P.A. 102-538, eff. 8-20-21.)

Section 95-10. The Illinois Insurance Code is amended by changing Section 5.5 as follows:

(215 ILCS 5/5.5)

Sec. 5.5. Compliance with the Department of Healthcare and Family Services. A company authorized to do business in this State or accredited by the State to issue policies of health insurance, including but not limited to, self-insured plans, group health plans (as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service as a condition of doing business in the State must:

(1) provide to the Department of Healthcare and Family Services, or any successor agency, on at least a quarterly basis if so requested by the Department, information to determine during what period any individual may be, or may have been, covered by a health insurer and the nature of the coverage that is or was provided by the health insurer, including the name, address, and identifying number of the plan;

(2) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or

service for which payment has been made under the medical programs of the Department of Healthcare and Family Services, or any successor or authorized agency, under this Code, ~~or~~ the Illinois Public Aid Code, or any other applicable law; and (other than parties expressly excluded under 42 U.S.C. 1396a(a)(25)(I)(ii)(II)) accept authorization provided by the State that the item or service is covered under such medical programs for the individual, as if the State's authorization was the prior authorization made by the company for the item or service;

(3) not later than 60 days after receiving ~~respond to~~ any inquiry by the Department of Healthcare and Family Services regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service, respond to such inquiry; and

(4) agree not to deny a claim submitted by the Department of Healthcare and Family Services solely on the basis of the date of submission of the claim, the type or format of the claim form, ~~or~~ a failure to present proper documentation at the point-of-sale that is the basis of the claim, or (other than parties expressly excluded under 42 U.S.C. 1396a(a)(25)(I)(iv)) a failure to obtain a prior authorization for the item or service for which the claim is being submitted if (i) the claim is submitted by the Department of Healthcare and Family Services within the

3-year period beginning on the date on which the item or service was furnished and (ii) any action by the Department of Healthcare and Family Services to enforce its rights with respect to such claim is commenced within 6 years of its submission of such claim.

The Department of Healthcare and Family Services may impose an administrative penalty as provided under Section 12-4.45 of the Illinois Public Aid Code on entities that have established a pattern of failure to provide the information required under this Section, or in cases in which the Department of Healthcare and Family Services has determined that an entity that provides health insurance coverage has established a pattern of failure to provide the information required under this Section, and has subsequently certified that determination, along with supporting documentation, to the Director of the Department of Insurance, the Director of the Department of Insurance, based upon the certification of determination made by the Department of Healthcare and Family Services, may commence regulatory proceedings in accordance with all applicable provisions of the Illinois Insurance Code.
(Source: P.A. 98-130, eff. 8-2-13.)

Section 95-15. The Illinois Public Aid Code is amended by changing Sections 5-5 and 12-8 as follows:

(305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant individuals, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use

disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; (16.5) services performed by a chiropractic physician licensed under the Medical Practice Act of 1987 and acting within the scope of his or her license, including, but not limited to, chiropractic manipulative treatment; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

Notwithstanding any other provision of this Section, a comprehensive tobacco use cessation program that includes

purchasing prescription drugs or prescription medical devices approved by the Food and Drug Administration shall be covered under the medical assistance program under this Article for persons who are otherwise eligible for assistance under this Article.

Notwithstanding any other provision of this Code, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article.

Notwithstanding any other provision of this Section, all tobacco cessation medications approved by the United States Food and Drug Administration and all individual and group tobacco cessation counseling services and telephone-based counseling services and tobacco cessation medications provided through the Illinois Tobacco Quitline shall be covered under the medical assistance program for persons who are otherwise eligible for assistance under this Article. The Department shall comply with all federal requirements necessary to obtain federal financial participation, as specified in 42 CFR 433.15(b)(7), for telephone-based counseling services provided through the Illinois Tobacco Quitline, including, but not limited to: (i) entering into a memorandum of understanding or interagency agreement with the Department of Public Health, as administrator of the Illinois Tobacco Quitline; and (ii) developing a cost allocation plan for Medicaid-allowable

Illinois Tobacco Quitline services in accordance with 45 CFR 95.507. The Department shall submit the memorandum of understanding or interagency agreement, the cost allocation plan, and all other necessary documentation to the Centers for Medicare and Medicaid Services for review and approval. Coverage under this paragraph shall be contingent upon federal approval.

Notwithstanding any other provision of this Code, the Illinois Department may not require, as a condition of payment for any laboratory test authorized under this Article, that a physician's handwritten signature appear on the laboratory test order form. The Illinois Department may, however, impose other appropriate requirements regarding laboratory test order documentation.

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department shall authorize the Chicago Public Schools (CPS) to procure a vendor or vendors to manufacture eyeglasses for individuals enrolled in a school within the CPS system. CPS shall ensure that its vendor or vendors are enrolled as providers in the medical assistance program and in any capitated Medicaid managed care entity (MCE) serving individuals enrolled in a school within the CPS system. Under any contract procured under this provision, the vendor or vendors must serve only individuals enrolled in a school within the CPS system. Claims for services provided by CPS's vendor or vendors to recipients

of benefits in the medical assistance program under this Code, the Children's Health Insurance Program, or the Covering ALL KIDS Health Insurance Program shall be submitted to the Department or the MCE in which the individual is enrolled for payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses.

On and after July 1, 2012, the Department of Healthcare and Family Services may provide the following services to persons eligible for assistance under this Article who are participating in education, training or employment programs operated by the Department of Human Services as successor to the Department of Public Aid:

(1) dental services provided by or under the supervision of a dentist; and

(2) eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select.

On and after July 1, 2018, the Department of Healthcare and Family Services shall provide dental services to any adult who is otherwise eligible for assistance under the medical assistance program. As used in this paragraph, "dental services" means diagnostic, preventative, restorative, or corrective procedures, including procedures and services for the prevention and treatment of periodontal disease and dental caries disease, provided by an individual who is licensed to practice dentistry or dental surgery or who is under the

supervision of a dentist in the practice of his or her profession.

On and after July 1, 2018, targeted dental services, as set forth in Exhibit D of the Consent Decree entered by the United States District Court for the Northern District of Illinois, Eastern Division, in the matter of Memisovski v. Maram, Case No. 92 C 1982, that are provided to adults under the medical assistance program shall be established at no less than the rates set forth in the "New Rate" column in Exhibit D of the Consent Decree for targeted dental services that are provided to persons under the age of 18 under the medical assistance program.

Notwithstanding any other provision of this Code and subject to federal approval, the Department may adopt rules to allow a dentist who is volunteering his or her service at no cost to render dental services through an enrolled not-for-profit health clinic without the dentist personally enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

On and after January 1, 2022, the Department of Healthcare

and Family Services shall administer and regulate a school-based dental program that allows for the out-of-office delivery of preventative dental services in a school setting to children under 19 years of age. The Department shall establish, by rule, guidelines for participation by providers and set requirements for follow-up referral care based on the requirements established in the Dental Office Reference Manual published by the Department that establishes the requirements for dentists participating in the All Kids Dental School Program. Every effort shall be made by the Department when developing the program requirements to consider the different geographic differences of both urban and rural areas of the State for initial treatment and necessary follow-up care. No provider shall be charged a fee by any unit of local government to participate in the school-based dental program administered by the Department. Nothing in this paragraph shall be construed to limit or preempt a home rule unit's or school district's authority to establish, change, or administer a school-based dental program in addition to, or independent of, the school-based dental program administered by the Department.

The Illinois Department, by rule, may distinguish and classify the medical services to be provided only in accordance with the classes of persons designated in Section 5-2.

The Department of Healthcare and Family Services must

provide coverage and reimbursement for amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

The Illinois Department shall authorize the provision of, and shall authorize payment for, screening by low-dose mammography for the presence of occult breast cancer for individuals 35 years of age or older who are eligible for medical assistance under this Article, as follows:

(A) A baseline mammogram for individuals 35 to 39 years of age.

(B) An annual mammogram for individuals 40 years of age or older.

(C) A mammogram at the age and intervals considered medically necessary by the individual's health care provider for individuals under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

(D) A comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice medicine in all of its branches.

(E) A screening MRI when medically necessary, as determined by a physician licensed to practice medicine in all of its branches.

(F) A diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.

The Department shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided under this paragraph; except that this sentence does not apply to coverage of diagnostic mammograms to the extent such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to Section 223 of the Internal Revenue Code (26 U.S.C. 223).

All screenings shall include a physical breast exam, instruction on self-examination and information regarding the frequency of self-examination and its value as a preventative tool.

For purposes of this Section:

"Diagnostic mammogram" means a mammogram obtained using diagnostic mammography.

"Diagnostic mammography" means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the

breast.

"Low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with an average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis.

"Breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation

for the cost of coverage for breast tomosynthesis set forth in this paragraph.

On and after January 1, 2016, the Department shall ensure that all networks of care for adult clients of the Department include access to at least one breast imaging Center of Imaging Excellence as certified by the American College of Radiology.

On and after January 1, 2012, providers participating in a quality improvement program approved by the Department shall be reimbursed for screening and diagnostic mammography at the same rate as the Medicare program's rates, including the increased reimbursement for digital mammography and, after January 1, 2023 (the effective date of Public Act 102-1018) ~~this amendatory Act of the 102nd General Assembly~~, breast tomosynthesis.

The Department shall convene an expert panel including representatives of hospitals, free-standing mammography facilities, and doctors, including radiologists, to establish quality standards for mammography.

On and after January 1, 2017, providers participating in a breast cancer treatment quality improvement program approved by the Department shall be reimbursed for breast cancer treatment at a rate that is no lower than 95% of the Medicare program's rates for the data elements included in the breast cancer treatment quality program.

The Department shall convene an expert panel, including

representatives of hospitals, free-standing breast cancer treatment centers, breast cancer quality organizations, and doctors, including breast surgeons, reconstructive breast surgeons, oncologists, and primary care providers to establish quality standards for breast cancer treatment.

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other hospital-based mammography facilities. By January 1, 2016, the Department shall report to the General Assembly on the status of the provision set forth in this paragraph.

The Department shall establish a methodology to remind individuals who are age-appropriate for screening mammography, but who have not received a mammogram within the previous 18 months, of the importance and benefit of screening mammography. The Department shall work with experts in breast cancer outreach and patient navigation to optimize these reminders and shall establish a methodology for evaluating their effectiveness and modifying the methodology based on the evaluation.

The Department shall establish a performance goal for primary care providers with respect to their female patients over age 40 receiving an annual mammogram. This performance goal shall be used to provide additional reimbursement in the form of a quality performance bonus to primary care providers

who meet that goal.

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. On or after July 1, 2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within metropolitan Chicago. An evaluation of the pilot program shall be carried out measuring health outcomes and cost of care for those served by the pilot program compared to similarly situated patients who are not served by the pilot program.

The Department shall require all networks of care to develop a means either internally or by contract with experts in navigation and community outreach to navigate cancer patients to comprehensive care in a timely fashion. The Department shall require all networks of care to include access for patients diagnosed with cancer to at least one academic commission on cancer-accredited cancer program as an in-network covered benefit.

The Department shall provide coverage and reimbursement for a human papillomavirus (HPV) vaccine that is approved for marketing by the federal Food and Drug Administration for all

persons between the ages of 9 and 45. Subject to federal approval, the Department shall provide coverage and reimbursement for a human papillomavirus (HPV) vaccine for ~~and~~ persons of the age of 46 and above who have been diagnosed with cervical dysplasia with a high risk of recurrence or progression. The Department shall disallow any preauthorization requirements for the administration of the human papillomavirus (HPV) vaccine.

On or after July 1, 2022, individuals who are otherwise eligible for medical assistance under this Article shall receive coverage for perinatal depression screenings for the 12-month period beginning on the last day of their pregnancy. Medical assistance coverage under this paragraph shall be conditioned on the use of a screening instrument approved by the Department.

Any medical or health care provider shall immediately recommend, to any pregnant individual who is being provided prenatal services and is suspected of having a substance use disorder as defined in the Substance Use Disorder Act, referral to a local substance use disorder treatment program licensed by the Department of Human Services or to a licensed hospital which provides substance abuse treatment services. The Department of Healthcare and Family Services shall assure coverage for the cost of treatment of the drug abuse or addiction for pregnant recipients in accordance with the Illinois Medicaid Program in conjunction with the Department

of Human Services.

All medical providers providing medical assistance to pregnant individuals under this Code shall receive information from the Department on the availability of services under any program providing case management services for addicted individuals, including information on appropriate referrals for other social services that may be needed by addicted individuals in addition to treatment for addiction.

The Illinois Department, in cooperation with the Departments of Human Services (as successor to the Department of Alcoholism and Substance Abuse) and Public Health, through a public awareness campaign, may provide information concerning treatment for alcoholism and drug abuse and addiction, prenatal health care, and other pertinent programs directed at reducing the number of drug-affected infants born to recipients of medical assistance.

Neither the Department of Healthcare and Family Services nor the Department of Human Services shall sanction the recipient solely on the basis of the recipient's substance abuse.

The Illinois Department shall establish such regulations governing the dispensing of health services under this Article as it shall deem appropriate. The Department should seek the advice of formal professional advisory committees appointed by the Director of the Illinois Department for the purpose of providing regular advice on policy and administrative matters,

information dissemination and educational activities for medical and health care providers, and consistency in procedures to the Illinois Department.

The Illinois Department may develop and contract with Partnerships of medical providers to arrange medical services for persons eligible under Section 5-2 of this Code. Implementation of this Section may be by demonstration projects in certain geographic areas. The Partnership shall be represented by a sponsor organization. The Department, by rule, shall develop qualifications for sponsors of Partnerships. Nothing in this Section shall be construed to require that the sponsor organization be a medical organization.

The sponsor must negotiate formal written contracts with medical providers for physician services, inpatient and outpatient hospital care, home health services, treatment for alcoholism and substance abuse, and other services determined necessary by the Illinois Department by rule for delivery by Partnerships. Physician services must include prenatal and obstetrical care. The Illinois Department shall reimburse medical services delivered by Partnership providers to clients in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

(1) Physicians participating in a Partnership and providing certain services, which shall be determined by the Illinois Department, to persons in areas covered by

the Partnership may receive an additional surcharge for such services.

(2) The Department may elect to consider and negotiate financial incentives to encourage the development of Partnerships and the efficient delivery of medical care.

(3) Persons receiving medical services through Partnerships may receive medical and case management services above the level usually offered through the medical assistance program.

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the delivery of high quality medical services. These qualifications shall be determined by rule of the Illinois Department and may be higher than qualifications for participation in the medical assistance program. Partnership sponsors may prescribe reasonable additional qualifications for participation by medical providers, only with the prior written approval of the Illinois Department.

Nothing in this Section shall limit the free choice of practitioners, hospitals, and other providers of medical services by clients. In order to ensure patient freedom of choice, the Illinois Department shall immediately promulgate all rules and take all other necessary actions so that provided services may be accessed from therapeutically certified optometrists to the full extent of the Illinois Optometric Practice Act of 1987 without discriminating between

service providers.

The Department shall apply for a waiver from the United States Health Care Financing Administration to allow for the implementation of Partnerships under this Section.

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and

eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after September 16, 1984 (the effective date of Public Act 83-1439), the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after July 22, 2013 (the effective date of Public Act 98-104), establish procedures to permit skilled care facilities licensed under the Nursing Home Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall, by July 1, 2016, test the

viability of the new system and implement any necessary operational or structural changes to its information technology platforms in order to allow for the direct acceptance and payment of nursing home claims.

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after August 15, 2014 (the effective date of Public Act 98-963), establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act and MC/DD facilities licensed under the MC/DD Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

The Illinois Department shall require all dispensers of medical services, other than an individual practitioner or group of practitioners, desiring to participate in the Medical Assistance program established under this Article to disclose all financial, beneficial, ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services in this State under this Article.

The Illinois Department may require that all dispensers of medical services desiring to participate in the medical

assistance program established under this Article disclose, under such terms and conditions as the Illinois Department may by rule establish, all inquiries from clients and attorneys regarding medical bills paid by the Illinois Department, which inquiries could indicate potential existence of claims or liens for the Illinois Department.

Enrollment of a vendor shall be subject to a provisional period and shall be conditional for one year. During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the medical assistance program without cause. Unless otherwise specified, such termination of eligibility or disenrollment is not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

The Department has the discretion to limit the conditional enrollment period for vendors based upon the category of risk of the vendor.

Prior to enrollment and during the conditional enrollment period in the medical assistance program, all vendors shall be subject to enhanced oversight, screening, and review based on the risk of fraud, waste, and abuse that is posed by the category of risk of the vendor. The Illinois Department shall establish the procedures for oversight, screening, and review, which may include, but need not be limited to: criminal and financial background checks; fingerprinting; license,

certification, and authorization verifications; unscheduled or unannounced site visits; database checks; prepayment audit reviews; audits; payment caps; payment suspensions; and other screening as required by federal or State law.

The Department shall define or specify the following: (i) by provider notice, the "category of risk of the vendor" for each type of vendor, which shall take into account the level of screening applicable to a particular category of vendor under federal law and regulations; (ii) by rule or provider notice, the maximum length of the conditional enrollment period for each category of risk of the vendor; and (iii) by rule, the hearing rights, if any, afforded to a vendor in each category of risk of the vendor that is terminated or disenrolled during the conditional enrollment period.

To be eligible for payment consideration, a vendor's payment claim or bill, either as an initial claim or as a resubmitted claim following prior rejection, must be received by the Illinois Department, or its fiscal intermediary, no later than 180 days after the latest date on the claim on which medical goods or services were provided, with the following exceptions:

(1) In the case of a provider whose enrollment is in process by the Illinois Department, the 180-day period shall not begin until the date on the written notice from the Illinois Department that the provider enrollment is complete.

(2) In the case of errors attributable to the Illinois Department or any of its claims processing intermediaries which result in an inability to receive, process, or adjudicate a claim, the 180-day period shall not begin until the provider has been notified of the error.

(3) In the case of a provider for whom the Illinois Department initiates the monthly billing process.

(4) In the case of a provider operated by a unit of local government with a population exceeding 3,000,000 when local government funds finance federal participation for claims payments.

For claims for services rendered during a period for which a recipient received retroactive eligibility, claims must be filed within 180 days after the Department determines the applicant is eligible. For claims for which the Illinois Department is not the primary payer, claims must be submitted to the Illinois Department within 180 days after the final adjudication by the primary payer.

In the case of long term care facilities, within 120 calendar days of receipt by the facility of required prescreening information, new admissions with associated admission documents shall be submitted through the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System or shall be submitted directly to the Department of Human Services using required admission forms. Effective September 1, 2014, admission

documents, including all prescreening information, must be submitted through MEDI or REV. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.

Claims that are not submitted and received in compliance with the foregoing requirements shall not be eligible for payment under the medical assistance program, and the State shall have no liability for payment of those claims.

To the extent consistent with applicable information and privacy, security, and disclosure laws, State and federal agencies and departments shall provide the Illinois Department access to confidential and other information and data necessary to perform eligibility and payment verifications and other Illinois Department functions. This includes, but is not limited to: information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

The Illinois Department shall enter into agreements with

State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Illinois Department shall develop, in cooperation with other State departments and agencies, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including, but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

Beginning in fiscal year 2013, the Illinois Department shall set forth a request for information to identify the benefits of a pre-payment, post-adjudication, and post-edit claims system with the goals of streamlining claims processing and provider reimbursement, reducing the number of pending or rejected claims, and helping to ensure a more transparent adjudication process through the utilization of: (i) provider data verification and provider screening technology; and (ii) clinical code editing; and (iii) pre-pay, pre-adjudicated ~~pre-~~ or post-adjudicated predictive modeling with an integrated

case management system with link analysis. Such a request for information shall not be considered as a request for proposal or as an obligation on the part of the Illinois Department to take any action or acquire any products or services.

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Subject to prior approval, such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department. Notwithstanding any provision of Section 5-5f to the contrary, the Department may, by rule, exempt certain replacement wheelchair parts from prior approval and, for wheelchairs, wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

The Department shall require, by rule, all providers of

durable medical equipment to be accredited by an accreditation organization approved by the federal Centers for Medicare and Medicaid Services and recognized by the Department in order to bill the Department for providing durable medical equipment to recipients. No later than 15 months after the effective date of the rule adopted pursuant to this paragraph, all providers must meet the accreditation requirement.

In order to promote environmental responsibility, meet the needs of recipients and enrollees, and achieve significant cost savings, the Department, or a managed care organization under contract with the Department, may provide recipients or managed care enrollees who have a prescription or Certificate of Medical Necessity access to refurbished durable medical equipment under this Section (excluding prosthetic and orthotic devices as defined in the Orthotics, Prosthetics, and Pedorthics Practice Act and complex rehabilitation technology products and associated services) through the State's assistive technology program's reutilization program, using staff with the Assistive Technology Professional (ATP) Certification if the refurbished durable medical equipment: (i) is available; (ii) is less expensive, including shipping costs, than new durable medical equipment of the same type; (iii) is able to withstand at least 3 years of use; (iv) is cleaned, disinfected, sterilized, and safe in accordance with federal Food and Drug Administration regulations and guidance governing the reprocessing of medical devices in health care

settings; and (v) equally meets the needs of the recipient or enrollee. The reutilization program shall confirm that the recipient or enrollee is not already in receipt of the same or similar equipment from another service provider, and that the refurbished durable medical equipment equally meets the needs of the recipient or enrollee. Nothing in this paragraph shall be construed to limit recipient or enrollee choice to obtain new durable medical equipment or place any additional prior authorization conditions on enrollees of managed care organizations.

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped; and (iii) notwithstanding any other provision of law, subject to federal approval, on and after July 1, 2012, an increase in the determination of need (DON) scores from 29 to 37 for applicants for institutional and home and community-based long term care; if and only if federal approval is not granted, the Department may, in conjunction with other affected agencies, implement utilization controls or changes in benefit packages to effectuate a similar savings

amount for this population; and (iv) no later than July 1, 2013, minimum level of care eligibility criteria for institutional and home and community-based long term care; and (v) no later than October 1, 2013, establish procedures to permit long term care providers access to eligibility scores for individuals with an admission date who are seeking or receiving services from the long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

The Illinois Department shall develop and operate, in cooperation with other State Departments and agencies and in compliance with applicable federal laws and regulations, appropriate and effective systems of health care evaluation and programs for monitoring of utilization of health care services and facilities, as it affects persons eligible for medical assistance under this Code.

The Illinois Department shall report annually to the General Assembly, no later than the second Friday in April of 1979 and each year thereafter, in regard to:

(a) actual statistics and trends in utilization of

medical services by public aid recipients;

(b) actual statistics and trends in the provision of the various medical services by medical vendors;

(c) current rate structures and proposed changes in those rate structures for the various medical vendors; and

(d) efforts at utilization review and control by the Illinois Department.

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act, and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate

of reimbursement for services or other payments in accordance with Section 5-5e.

Because kidney transplantation can be an appropriate, cost-effective alternative to renal dialysis when medically necessary and notwithstanding the provisions of Section 1-11 of this Code, beginning October 1, 2014, the Department shall cover kidney transplantation for noncitizens with end-stage renal disease who are not eligible for comprehensive medical benefits, who meet the residency requirements of Section 5-3 of this Code, and who would otherwise meet the financial requirements of the appropriate class of eligible persons under Section 5-2 of this Code. To qualify for coverage of kidney transplantation, such person must be receiving emergency renal dialysis services covered by the Department. Providers under this Section shall be prior approved and certified by the Department to perform kidney transplantation and the services under this Section shall be limited to services associated with kidney transplantation.

Notwithstanding any other provision of this Code to the contrary, on or after July 1, 2015, all FDA approved forms of medication assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be covered under both fee for service and managed care medical assistance programs for persons who are otherwise eligible for medical assistance under this Article and shall not be subject to any (1) utilization control, other than those established

under the American Society of Addiction Medicine patient placement criteria, (2) prior authorization mandate, or (3) lifetime restriction limit mandate.

On or after July 1, 2015, opioid antagonists prescribed for the treatment of an opioid overdose, including the medication product, administration devices, and any pharmacy fees or hospital fees related to the dispensing, distribution, and administration of the opioid antagonist, shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article. As used in this Section, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration. The Department shall not impose a copayment on the coverage provided for naloxone hydrochloride under the medical assistance program.

Upon federal approval, the Department shall provide coverage and reimbursement for all drugs that are approved for marketing by the federal Food and Drug Administration and that are recommended by the federal Public Health Service or the United States Centers for Disease Control and Prevention for pre-exposure prophylaxis and related pre-exposure prophylaxis services, including, but not limited to, HIV and sexually transmitted infection screening, treatment for sexually

transmitted infections, medical monitoring, assorted labs, and counseling to reduce the likelihood of HIV infection among individuals who are not infected with HIV but who are at high risk of HIV infection.

A federally qualified health center, as defined in Section 1905(l)(2)(B) of the federal Social Security Act, shall be reimbursed by the Department in accordance with the federally qualified health center's encounter rate for services provided to medical assistance recipients that are performed by a dental hygienist, as defined under the Illinois Dental Practice Act, working under the general supervision of a dentist and employed by a federally qualified health center.

Within 90 days after October 8, 2021 (the effective date of Public Act 102-665), the Department shall seek federal approval of a State Plan amendment to expand coverage for family planning services that includes presumptive eligibility to individuals whose income is at or below 208% of the federal poverty level. Coverage under this Section shall be effective beginning no later than December 1, 2022.

Subject to approval by the federal Centers for Medicare and Medicaid Services of a Title XIX State Plan amendment electing the Program of All-Inclusive Care for the Elderly (PACE) as a State Medicaid option, as provided for by Subtitle I (commencing with Section 4801) of Title IV of the Balanced Budget Act of 1997 (Public Law 105-33) and Part 460 (commencing with Section 460.2) of Subchapter E of Title 42 of

the Code of Federal Regulations, PACE program services shall become a covered benefit of the medical assistance program, subject to criteria established in accordance with all applicable laws.

Notwithstanding any other provision of this Code, community-based pediatric palliative care from a trained interdisciplinary team shall be covered under the medical assistance program as provided in Section 15 of the Pediatric Palliative Care Act.

Notwithstanding any other provision of this Code, within 12 months after June 2, 2022 (the effective date of Public Act 102-1037) ~~this amendatory Act of the 102nd General Assembly~~ and subject to federal approval, acupuncture services performed by an acupuncturist licensed under the Acupuncture Practice Act who is acting within the scope of his or her license shall be covered under the medical assistance program. The Department shall apply for any federal waiver or State Plan amendment, if required, to implement this paragraph. The Department may adopt any rules, including standards and criteria, necessary to implement this paragraph.

(Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff. 5-13-22;

102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22; 102-1038 eff. 1-1-23; revised 2-5-23.)

(305 ILCS 5/12-8) (from Ch. 23, par. 12-8)

Sec. 12-8. Public Assistance Emergency Revolving Fund - Uses. The Public Assistance Emergency Revolving Fund, established by Act approved July 8, 1955 shall be held by the Illinois Department and shall be used for the following purposes:

1. To provide immediate financial aid to applicants in acute need who have been determined eligible for aid under Articles III, IV, or V.

2. To provide emergency aid to recipients under said Articles who have failed to receive their grants because of mail box or other thefts, or who are victims of a burnout, eviction, or other circumstances causing privation, in which cases the delays incident to the issuance of grants from appropriations would cause hardship and suffering.

3. To provide emergency aid for transportation, meals and lodging to applicants who are referred to cities other than where they reside for physical examinations to establish blindness or disability, or to determine the incapacity of the parent of a dependent child.

4. To provide emergency transportation expense allowances to recipients engaged in vocational training

and rehabilitation projects.

5. To assist public aid applicants in obtaining copies of birth certificates, death certificates, marriage licenses or other similar legal documents which may facilitate the verification of eligibility for public aid under this Code.

6. To provide immediate payments to current or former recipients of child support enforcement services, or refunds to responsible relatives, for child support made to the Illinois Department under Title IV-D of the Social Security Act when such recipients of services or responsible relatives are legally entitled to all or part of such child support payments under applicable State or federal law.

7. To provide payments to individuals or providers of transportation to and from medical care for the benefit of recipients under Articles III, IV, V, and VI.

8. To provide immediate payment of fees, as follows:

(A) To sheriffs and other public officials authorized by law to serve process in judicial and administrative child support actions in the State of Illinois and other states.

(B) To county clerks, recorders of deeds, and other public officials and keepers of real property records in order to perfect and release real property liens.

(C) To State and local officials in connection with the processing of Qualified Illinois Domestic Relations Orders.

(D) To the State Registrar of Vital Records, local registrars of vital records, or other public officials and keepers of voluntary acknowledgment of paternity forms.

Disbursements from the Public Assistance Emergency Revolving Fund shall be made by the Illinois Department.

Expenditures from the Public Assistance Emergency Revolving Fund shall be for purposes which are properly chargeable to appropriations made to the Illinois Department, or, in the case of payments under subparagraphs 6 and 8, to the Child Support Enforcement Trust Fund or the Child Support Administrative Fund, except that no expenditure, other than payment of the fees provided for under subparagraph 8 of this Section, shall be made for purposes which are properly chargeable to appropriations for the following objects: personal services; extra help; state contributions to retirement system; state contributions to Social Security; state contributions for employee group insurance; contractual services; travel; commodities; printing; equipment; electronic data processing; operation of auto equipment; telecommunications services; library books; and refunds. The Illinois Department shall reimburse the Public Assistance Emergency Revolving Fund by warrants drawn by the State

Comptroller on the appropriation or appropriations which are so chargeable, or, in the case of payments under subparagraphs 6 and 8, by warrants drawn on the Child Support Enforcement Trust Fund or the Child Support Administrative Fund, payable to the Revolving Fund.

(Source: P.A. 97-735, eff. 7-3-12.)

ARTICLE 100.

Section 100-5. The Illinois Public Aid Code is amended by changing Section 5-5.01a as follows:

(305 ILCS 5/5-5.01a)

Sec. 5-5.01a. Supportive living facilities program.

(a) The Department shall establish and provide oversight for a program of supportive living facilities that seek to promote resident independence, dignity, respect, and well-being in the most cost-effective manner.

A supportive living facility is (i) a free-standing facility or (ii) a distinct physical and operational entity within a mixed-use building that meets the criteria established in subsection (d). A supportive living facility integrates housing with health, personal care, and supportive services and is a designated setting that offers residents their own separate, private, and distinct living units.

Sites for the operation of the program shall be selected

by the Department based upon criteria that may include the need for services in a geographic area, the availability of funding, and the site's ability to meet the standards.

(b) Beginning July 1, 2014, subject to federal approval, the Medicaid rates for supportive living facilities shall be equal to the supportive living facility Medicaid rate effective on June 30, 2014 increased by 8.85%. Once the assessment imposed at Article V-G of this Code is determined to be a permissible tax under Title XIX of the Social Security Act, the Department shall increase the Medicaid rates for supportive living facilities effective on July 1, 2014 by 9.09%. The Department shall apply this increase retroactively to coincide with the imposition of the assessment in Article V-G of this Code in accordance with the approval for federal financial participation by the Centers for Medicare and Medicaid Services.

The Medicaid rates for supportive living facilities effective on July 1, 2017 must be equal to the rates in effect for supportive living facilities on June 30, 2017 increased by 2.8%.

The Medicaid rates for supportive living facilities effective on July 1, 2018 must be equal to the rates in effect for supportive living facilities on June 30, 2018.

Subject to federal approval, the Medicaid rates for supportive living services on and after July 1, 2019 must be at least 54.3% of the average total nursing facility services per

diem for the geographic areas defined by the Department while maintaining the rate differential for dementia care and must be updated whenever the total nursing facility service per diems are updated. Beginning July 1, 2022, upon the implementation of the Patient Driven Payment Model, Medicaid rates for supportive living services must be at least 54.3% of the average total nursing services per diem rate for the geographic areas. For purposes of this provision, the average total nursing services per diem rate shall include all add-ons for nursing facilities for the geographic area provided for in Section 5-5.2. The rate differential for dementia care must be maintained in these rates and the rates shall be updated whenever nursing facility per diem rates are updated.

(c) The Department may adopt rules to implement this Section. Rules that establish or modify the services, standards, and conditions for participation in the program shall be adopted by the Department in consultation with the Department on Aging, the Department of Rehabilitation Services, and the Department of Mental Health and Developmental Disabilities (or their successor agencies).

(d) Subject to federal approval by the Centers for Medicare and Medicaid Services, the Department shall accept for consideration of certification under the program any application for a site or building where distinct parts of the site or building are designated for purposes other than the provision of supportive living services, but only if:

(1) those distinct parts of the site or building are not designated for the purpose of providing assisted living services as required under the Assisted Living and Shared Housing Act;

(2) those distinct parts of the site or building are completely separate from the part of the building used for the provision of supportive living program services, including separate entrances;

(3) those distinct parts of the site or building do not share any common spaces with the part of the building used for the provision of supportive living program services; and

(4) those distinct parts of the site or building do not share staffing with the part of the building used for the provision of supportive living program services.

(e) Facilities or distinct parts of facilities which are selected as supportive living facilities and are in good standing with the Department's rules are exempt from the provisions of the Nursing Home Care Act and the Illinois Health Facilities Planning Act.

(f) Section 9817 of the American Rescue Plan Act of 2021 (Public Law 117-2) authorizes a 10% enhanced federal medical assistance percentage for supportive living services for a 12-month period from April 1, 2021 through March 31, 2022. Subject to federal approval, including the approval of any necessary waiver amendments or other federally required

documents or assurances, for a 12-month period the Department must pay a supplemental $26 per diem rate to all supportive living facilities with the additional federal financial participation funds that result from the enhanced federal medical assistance percentage from April 1, 2021 through March 31, 2022. The Department may issue parameters around how the supplemental payment should be spent, including quality improvement activities. The Department may alter the form, methods, or timeframes concerning the supplemental per diem rate to comply with any subsequent changes to federal law, changes made by guidance issued by the federal Centers for Medicare and Medicaid Services, or other changes necessary to receive the enhanced federal medical assistance percentage.

(g) All applications for the expansion of supportive living dementia care settings involving sites not approved by the Department on the effective date of this amendatory Act of the 103rd General Assembly may allow new elderly non-dementia units in addition to new dementia care units. The Department may approve such applications only if the application has: (1) no more than one non-dementia care unit for each dementia care unit and (2) the site is not located within 4 miles of an existing supportive living program site in Cook County (including the City of Chicago), not located within 12 miles of an existing supportive living program site in DuPage County, Kane County, Lake County, McHenry County, or Will County, or not located within 25 miles of an existing

supportive living program site in any other county.

(Source: P.A. 101-10, eff. 6-5-19; 102-43, eff. 7-6-21; 102-699, eff. 4-19-22.)

ARTICLE 105.

Section 105-5. The Illinois Public Aid Code is amended by changing Section 5A-2 as follows:

(305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

(Section scheduled to be repealed on December 31, 2026)

Sec. 5A-2. Assessment.

(a)(1) Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2018, or as long as continued under Section 5A-16, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided, however, that the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period of April through June 2015, the amount of $218.38 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of

Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $20,250,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, or as provided in Section 5A-16, in addition to any federally required State share as authorized under paragraph (1), the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

For State fiscal years 2009 through 2018, or as provided in Section 5A-16, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or

its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $197.19 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days. For State fiscal years 2019 and 2020, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10 and to subsection

(b-8), for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $221.50 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided however: for the period of July 1, 2020 through December 31, 2020, (i) the assessment shall be equal to 50% of the annual amount; and (ii) the amount of $221.50 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the

assessment methodology for fiscal years 2021 through December 31, 2022 not be approved on or before June 30, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the assessment methodology for July 1, 2020 through December 31, 2022, is approved on or after July 1, 2020, it shall be retroactive to July 1, 2020, subject to federal approval and provided that the payments authorized under Section 5A-12.7 have the same effective date as the new assessment methodology. In giving retroactive effect to the assessment approved after June 30, 2020, credit toward the new assessment shall be given for any payments of the previous assessment for periods after June 30, 2020. Notwithstanding any other provision of this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this paragraph until December 31, 2023. Beginning July 1, 2022 and through December 31, 2024, a safety-net hospital that had a change of ownership in calendar year 2021, and whose inpatient utilization had decreased by 90% from the prior year and prior to the change of ownership, may be eligible to pay a tax based on hypothetical data based on a determination of financial distress by the Department. Subject to federal approval, the Department may, by January 1, 2024, develop a

hypothetical tax for a specialty cancer hospital which had a structural change of ownership during calendar year 2022 from a for-profit entity to a non-profit entity, and which has experienced a decline of 60% or greater in inpatient days of care as compared to the prior owners 2015 Medicare cost report. This change of ownership may make the hospital eligible for a hypothetical tax under the new hospital provision of the assessment defined in this Section. This new hypothetical tax may be applicable from January 1, 2024 through December 31, 2026.

(b) (Blank).

(b-5)(1) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, or as provided in Section 5A-16, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 5A-12.5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator

of which is 21 days and the denominator of which is 365 days. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $6,750,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph.

(2) In addition to any other assessments imposed under this Article, effective July 1, 2016 and semi-annually thereafter through June 2018, in addition to any federally required State share as authorized under paragraph (1), the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the ACA Assessment Adjustment, as defined in subsection (b-6) of this Section.

For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018, or as provided in Section 5A-16, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross

revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

(3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State fiscal years 2019 and 2020, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01358 multiplied by the hospital's outpatient gross revenue. For State fiscal years 2019 and 2020, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees. Notwithstanding any other provision in this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State fiscal year 2018 on the basis of hypothetical data, that assessment amount shall be used for State fiscal years 2019 and 2020.

(4) Subject to Sections 5A-3 and 5A-10 and to subsection (b-8), for the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .01525 multiplied by the hospital's outpatient gross revenue, provided however: (i) for the period of July 1, 2020 through December 31, 2020, the assessment shall be equal to 50% of the annual amount; and (ii) the amount of .01525 shall be retroactively adjusted by a uniform percentage to generate an amount equal to 50% of the Assessment Adjustment, as defined in subsection (b-7). For the period of July 1, 2020 through December 31, 2020 and calendar years 2021 through 2026, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2015 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on March 31, 2017, without regard to any subsequent adjustments or changes to such data. If a hospital's 2015 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's outpatient revenue data from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees. Should the change in the assessment methodology

above for fiscal years 2021 through calendar year 2022 not be approved prior to July 1, 2020, the assessment and payments under this Article in effect for fiscal year 2020 shall remain in place until the new assessment is approved. If the change in the assessment methodology above for July 1, 2020 through December 31, 2022, is approved after June 30, 2020, it shall have a retroactive effective date of July 1, 2020, subject to federal approval and provided that the payments authorized under Section 12A-7 have the same effective date as the new assessment methodology. In giving retroactive effect to the assessment approved after June 30, 2020, credit toward the new assessment shall be given for any payments of the previous assessment for periods after June 30, 2020. Notwithstanding any other provision of this Article, for a hospital provider that did not have a 2015 Medicare cost report, but paid an assessment in State Fiscal Year 2020 on the basis of hypothetical data, the data that was the basis for the 2020 assessment shall be used to calculate the assessment under this paragraph until December 31, 2023. Beginning July 1, 2022 and through December 31, 2024, a safety-net hospital that had a change of ownership in calendar year 2021, and whose inpatient utilization had decreased by 90% from the prior year and prior to the change of ownership, may be eligible to pay a tax based on hypothetical data based on a determination of financial distress by the Department.

(b-6)(1) As used in this Section, "ACA Assessment

Adjustment" means:

(A) For the period of July 1, 2016 through December 31, 2016, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of April 2016 multiplied by 6.

(B) For the period of January 1, 2017 through June 30, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2016 multiplied by 6, except that the amount calculated under this subparagraph (B) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning July 1, 2016 through December 31, 2016 and the estimated payments due and payable in the month of April 2016 multiplied by 6 as described in subparagraph (A).

(C) For the period of July 1, 2017 through December 31, 2017, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under

subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of April 2017 multiplied by 6, except that the amount calculated under this subparagraph (C) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period beginning January 1, 2017 through June 30, 2017 and the estimated payments due and payable in the month of October 2016 multiplied by 6 as described in subparagraph (B).

(D) For the period of January 1, 2018 through June 30, 2018, the product of .19125 multiplied by the sum of the fee-for-service payments to hospitals as authorized under Section 5A-12.5 and the adjustments authorized under subsection (t) of Section 5A-12.2 to managed care organizations for hospital services due and payable in the month of October 2017 multiplied by 6, except that:

(i) the amount calculated under this subparagraph (D) shall be adjusted, either positively or negatively, to account for the difference between the actual payments issued under Section 5A-12.5 for the period of July 1, 2017 through December 31, 2017 and the estimated payments due and payable in the month of April 2017 multiplied by 6 as described in subparagraph (C); and

(ii) the amount calculated under this subparagraph

(D) shall be adjusted to include the product of .19125 multiplied by the sum of the fee-for-service payments, if any, estimated to be paid to hospitals under subsection (b) of Section 5A-12.5.

(2) The Department shall complete and apply a final reconciliation of the ACA Assessment Adjustment prior to June 30, 2018 to account for:

(A) any differences between the actual payments issued or scheduled to be issued prior to June 30, 2018 as authorized in Section 5A-12.5 for the period of January 1, 2018 through June 30, 2018 and the estimated payments due and payable in the month of October 2017 multiplied by 6 as described in subparagraph (D); and

(B) any difference between the estimated fee-for-service payments under subsection (b) of Section 5A-12.5 and the amount of such payments that are actually scheduled to be paid.

The Department shall notify hospitals of any additional amounts owed or reduction credits to be applied to the June 2018 ACA Assessment Adjustment. This is to be considered the final reconciliation for the ACA Assessment Adjustment.

(3) Notwithstanding any other provision of this Section, if for any reason the scheduled payments under subsection (b) of Section 5A-12.5 are not issued in full by the final day of the period authorized under subsection (b) of Section 5A-12.5, funds collected from each hospital pursuant to subparagraph

(D) of paragraph (1) and pursuant to paragraph (2), attributable to the scheduled payments authorized under subsection (b) of Section 5A-12.5 that are not issued in full by the final day of the period attributable to each payment authorized under subsection (b) of Section 5A-12.5, shall be refunded.

(4) The increases authorized under paragraph (2) of subsection (a) and paragraph (2) of subsection (b-5) shall be limited to the federally required State share of the total payments authorized under Section 5A-12.5 if the sum of such payments yields an annualized amount equal to or less than $450,000,000, or if the adjustments authorized under subsection (t) of Section 5A-12.2 are found not to be actuarially sound; however, this limitation shall not apply to the fee-for-service payments described in subsection (b) of Section 5A-12.5.

(b-7)(1) As used in this Section, "Assessment Adjustment" means:

(A) For the period of July 1, 2020 through December 31, 2020, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7 attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(B) For each calendar quarter beginning January 1, 2021 through December 31, 2022, the product of .3853

multiplied by the total of the actual payments made under subsections (c) through (k) of Section 5A-12.7 attributable to the period, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the period.

(C) Beginning on January 1, 2023, and each subsequent July 1 and January 1, the product of .3853 multiplied by the total of the actual payments made under subsections (c) through (j) of Section 5A-12.7 attributable to the 6-month period immediately preceding the period to which the adjustment applies, less the total of the assessment imposed under subsections (a) and (b-5) of this Section for the 6-month period immediately preceding the period to which the adjustment applies.

(2) The Department shall calculate and notify each hospital of the total Assessment Adjustment and any additional assessment owed by the hospital or refund owed to the hospital on either a semi-annual or annual basis. Such notice shall be issued at least 30 days prior to any period in which the assessment will be adjusted. Any additional assessment owed by the hospital or refund owed to the hospital shall be uniformly applied to the assessment owed by the hospital in monthly installments for the subsequent semi-annual period or calendar year. If no assessment is owed in the subsequent year, any amount owed by the hospital or refund due to the hospital, shall be paid in a lump sum.

(3) The Department shall publish all details of the Assessment Adjustment calculation performed each year on its website within 30 days of completing the calculation, and also submit the details of the Assessment Adjustment calculation as part of the Department's annual report to the General Assembly.

(b-8) Notwithstanding any other provision of this Article, the Department shall reduce the assessments imposed on each hospital under subsections (a) and (b-5) by the uniform percentage necessary to reduce the total assessment imposed on all hospitals by an aggregate amount of $240,000,000, with such reduction being applied by June 30, 2022. The assessment reduction required for each hospital under this subsection shall be forever waived, forgiven, and released by the Department.

(c) (Blank).

(d) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section, as authorized by Section 5-46.2 of the Illinois Administrative Procedure Act.

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall

be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

(Source: P.A. 101-10, eff. 6-5-19; 101-650, eff. 7-7-20; reenacted by P.A. 101-655, eff. 3-12-21; 102-886, eff. 5-17-22.)

ARTICLE 110.

Section 110-5. The Illinois Insurance Code is amended by adding Section 513b7 as follows:

(215 ILCS 5/513b7 new)

Sec. 513b7. Pharmacy audits.

(a) As used in this Section:

"Audit" means any physical on-site, remote electronic, or concurrent review of a pharmacist or pharmacy service submitted to the pharmacy benefit manager or pharmacy benefit manager affiliate by a pharmacist or pharmacy for payment.

"Auditing entity" means a person or company that performs a pharmacy audit.

"Extrapolation" means the practice of inferring a frequency of dollar amount of overpayments, underpayments, nonvalid claims, or other errors on any portion of claims submitted, based on the frequency of dollar amount of overpayments, underpayments, nonvalid claims, or other errors actually measured in a sample of claims.

"Misfill" means a prescription that was not dispensed; a prescription that was dispensed but was an incorrect dose, amount, or type of medication; a prescription that was dispensed to the wrong person; a prescription in which the prescriber denied the authorization request; or a prescription in which an additional dispensing fee was charged.

"Pharmacy audit" means an audit conducted of any records of a pharmacy for prescriptions dispensed or nonproprietary

drugs or pharmacist services provided by a pharmacy or pharmacist to a covered person.

"Pharmacy record" means any record stored electronically or as a hard copy by a pharmacy that relates to the provision of a prescription or pharmacy services or other component of pharmacist care that is included in the practice of pharmacy.

(b) Notwithstanding any other law, when conducting a pharmacy audit, an auditing entity shall:

(1) not conduct an on-site audit of a pharmacy at any time during the first 3 business days of a month or the first 2 weeks and final 2 weeks of the calendar year or during a declared State or federal public health emergency;

(2) notify the pharmacy or its contracting agent no later than 14 business days before the date of initial on-site audit; the notification to the pharmacy or its contracting agent shall be in writing and delivered either:

(A) by mail or common carrier, return receipt requested; or

(B) electronically, not including facsimile, with electronic receipt confirmation and delivered during normal business hours of operation, addressed to the supervising pharmacist and pharmacy corporate office, if applicable, at least 14 business days before the date of an initial on-site audit;

(3) limit the audit period to 24 months after the date a claim is submitted to or adjudicated by the pharmacy benefit manager;

(4) provide in writing the list of specific prescription numbers to be included in the audit 14 business days before the on-site audit that may or may not include the final 2 digits of the prescription numbers;

(5) use the written and verifiable records of a hospital, physician, or other authorized practitioner that are transmitted by any means of communication to validate the pharmacy records in accordance with State and federal law;

(6) limit the number of prescriptions audited to no more than 100 prescriptions per audit and an entity shall not audit more than 200 prescriptions in any 12-month period, except in cases of fraud or knowing and willful misrepresentation; a refill shall not constitute a separate prescription and a pharmacy shall not be audited more than once every 6 months;

(7) provide the pharmacy or its contracting agent with a copy of the preliminary audit report within 45 days after the conclusion of the audit;

(8) be allowed to conduct a follow-up audit on site if a remote or desk audit reveals the necessity for a review of additional claims;

(9) accept invoice audits as validation invoices from

any wholesaler registered with the Department of Financial and Professional Regulation from which the pharmacy has purchased prescription drugs or, in the case of durable medical equipment or sickroom supplies, invoices from an authorized distributor other than a wholesaler;

(10) provide the pharmacy or its contracting agent with the ability to provide documentation to address a discrepancy or audit finding if the documentation is received by the pharmacy benefit manager no later than the 45th day after the preliminary audit report was provided to the pharmacy or its contracting agent; the pharmacy benefit manager shall consider a reasonable request from the pharmacy for an extension of time to submit documentation to address or correct any findings in the report;

(11) be required to provide the pharmacy or its contracting agent with the final audit report no later than 90 days after the initial audit report was provided to the pharmacy or its contracting agent;

(12) conduct the audit in consultation with a pharmacist in specific cases if the audit involves clinical or professional judgment;

(13) not chargeback, recoup, or collect penalties from a pharmacy until the time period to file an appeal of the final pharmacy audit report has passed or the appeals process has been exhausted, whichever is later, unless the

identified discrepancy is expected to exceed $25,000, in which case the auditing entity may withhold future payments in excess of that amount until the final resolution of the audit;

(14) not compensate the employee or contractor conducting the audit based on a percentage of the amount claimed or recouped pursuant to the audit;

(15) not use extrapolation to calculate penalties or amounts to be charged back or recouped unless otherwise required by federal law or regulation; any amount to be charged back or recouped due to overpayment may not exceed the amount the pharmacy was overpaid;

(16) not include dispensing fees in the calculation of overpayments unless a prescription is considered a misfill, the medication is not delivered to the patient, the prescription is not valid, or the prescriber denies authorizing the prescription; and

(17) conduct a pharmacy audit under the same standards and parameters as conducted for other similarly situated pharmacies audited by the auditing entity.

(c) Except as otherwise provided by State or federal law, an auditing entity conducting a pharmacy audit may have access to a pharmacy's previous audit report only if the report was prepared by that auditing entity.

(d) Information collected during a pharmacy audit shall be confidential by law, except that the auditing entity

conducting the pharmacy audit may share the information with the health benefit plan for which a pharmacy audit is being conducted and with any regulatory agencies and law enforcement agencies as required by law.

(e) A pharmacy may not be subject to a chargeback or recoupment for a clerical or recordkeeping error in a required document or record, including a typographical error or computer error, unless the pharmacy benefit manager can provide proof of intent to commit fraud or such error results in actual financial harm to the pharmacy benefit manager, a health plan managed by the pharmacy benefit manager, or a consumer.

(f) A pharmacy shall have the right to file a written appeal of a preliminary and final pharmacy audit report in accordance with the procedures established by the entity conducting the pharmacy audit.

(g) No interest shall accrue for any party during the audit period, beginning with the notice of the pharmacy audit and ending with the conclusion of the appeals process.

(h) An auditing entity must provide a copy to the plan sponsor of its claims that were included in the audit, and any recouped money shall be returned to the plan sponsor, unless otherwise contractually agreed upon by the plan sponsor and the pharmacy benefit manager.

(i) The parameters of an audit must comply with manufacturer listings or recommendations, unless otherwise

prescribed by the treating provider, and must be covered under the individual's health plan, for the following:

(1) the day supply for eye drops must be calculated so that the consumer pays only one 30-day copayment if the bottle of eye drops is intended by the manufacturer to be a 30-day supply;

(2) the day supply for insulin must be calculated so that the highest dose prescribed is used to determine the day supply and consumer copayment; and

(3) the day supply for topical product must be determined by the judgment of the pharmacist or treating provider upon the treated area.

(j) This Section shall not apply to:

(1) audits in which suspected fraud or knowing and willful misrepresentation is evidenced by a physical review, review of claims data or statements, or other investigative methods;

(2) audits of claims paid for by federally funded programs not applicable to health insurance coverage regulated by the Department; or

(3) concurrent reviews or desk audits that occur within 3 business days after transmission of a claim and in which no chargeback or recoupment is demanded.

ARTICLE 115.

Section 115-5. The Illinois Public Aid Code is amended by changing Section 5-30.11 as follows:

(305 ILCS 5/5-30.11)

Sec. 5-30.11. Treatment of autism spectrum disorder. Treatment of autism spectrum disorder through applied behavior analysis shall be covered under the medical assistance program under this Article for children with a diagnosis of autism spectrum disorder when (1) ordered by~~: (1)~~ a physician licensed to practice medicine in all its branches or a psychologist licensed by the Department of Financial and Professional Regulation and (2) ~~and rendered by a licensed or certified health care professional with expertise in applied behavior analysis; or (2) when~~ evaluated ~~and treated~~ by a behavior analyst as recognized by the Department or licensed by the Department of Financial and Professional Regulation to practice applied behavior analysis in this State. Such coverage may be limited to age ranges based on evidence-based best practices. Appropriate State plan amendments as well as rules regarding provision of services and providers will be submitted by September 1, 2019. Pursuant to the flexibilities allowed by the federal Centers for Medicare and Medicaid Services to Illinois under the Medical Assistance Program, the Department shall enroll and reimburse qualified staff to perform applied behavior analysis services in advance of Illinois licensure activities performed by the Department of

Financial and Professional Regulation. These services shall be covered if they are provided in a home or community setting or in an office-based setting. The Department may conduct annual on-site reviews of the services authorized under this Section. Provider enrollment shall occur no later than September 1, 2023.

(Source: P.A. 101-10, eff. 6-5-19; 102-558, eff. 8-20-21; 102-953, eff. 5-27-22.)

ARTICLE 120.

Section 120-5. The Illinois Public Aid Code is amended by adding Section 5-5a.1 as follows:

(305 ILCS 5/5-5a.1 new)

Sec. 5-5a.1. Telehealth services for persons with intellectual and developmental disabilities. The Department shall file an amendment to the Home and Community-Based Services Waiver Program for Adults with Developmental Disabilities authorized under Section 1915(c) of the Social Security Act to incorporate telehealth services administered by a provider of telehealth services that demonstrates knowledge and experience in providing medical and emergency services for persons with intellectual and developmental disabilities. The Department shall pay administrative fees associated with implementing telehealth services for all

persons with intellectual and developmental disabilities who are receiving services under the Home and Community-Based Services Waiver Program for Adults with Developmental Disabilities.

ARTICLE 125.

Section 125-5. The Illinois Public Aid Code is amended by adding Section 5-48 as follows:

(305 ILCS 5/5-48 new)

Sec. 5-48. Increasing behavioral health service capacity in federally qualified health centers. The Department of Healthcare and Family Services shall develop policies and procedures with the goal of increasing the capacity of behavioral health services provided by federally qualified health centers as defined in Section 1905(l)(2)(B) of the federal Social Security Act. Subject to federal approval, the Department shall develop, no later than January 1, 2024, billing policies that provide reimbursement to federally qualified health centers for services rendered by graduate-level, sub-clinical behavioral health professionals who deliver care under the supervision of a fully licensed behavioral health clinician who is licensed as a clinical social worker, clinical professional counselor, marriage and family therapist, or clinical psychologist.

To be eligible for reimbursement as provided for in this Section, a graduate-level, sub-clinical professional must meet the educational requirements set forth by the Department of Financial and Professional Regulation for licensed clinical social workers, licensed clinical professional counselors, licensed marriage and family therapists, or licensed clinical psychologists. An individual seeking to fulfill post-degree experience requirements in order to qualify for licensing as a clinical social worker, clinical professional counselor, marriage and family therapist, or clinical psychologist shall also be eligible for reimbursement under this Section so long as the individual is in compliance with all applicable laws and regulations regarding supervision, including, but not limited to, the requirement that the supervised experience be under the order, control, and full professional responsibility of the individual's supervisor or that the individual is designated by a title that clearly indicates training status.

The Department shall work with a trade association representing a majority of federally qualified health centers operating in Illinois to develop the policies and procedures required under this Section.

ARTICLE 130.

Section 130-5. The Illinois Insurance Code is amended by changing Section 363 as follows:

(215 ILCS 5/363) (from Ch. 73, par. 975)

Sec. 363. Medicare supplement policies; minimum standards.

(1) Except as otherwise specifically provided therein, this Section and Section 363a of this Code shall apply to:

(a) all Medicare supplement policies and subscriber contracts delivered or issued for delivery in this State on and after January 1, 1989; and

(b) all certificates issued under group Medicare supplement policies or subscriber contracts, which certificates are issued or issued for delivery in this State on and after January 1, 1989.

This Section shall not apply to "Accident Only" or "Specified Disease" types of policies. The provisions of this Section are not intended to prohibit or apply to policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons, which policies or plans are not marketed or purported or held to be Medicare supplement policies or benefit plans.

(2) For the purposes of this Section and Section 363a, the following terms have the following meanings:

(a) "Applicant" means:

(i) in the case of individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(ii) in the case of a group Medicare policy or

subscriber contract, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.

(c) "Medicare supplement policy" means an individual policy of accident and health insurance, as defined in paragraph (a) of subsection (2) of Section 355a of this Code, or a group policy or certificate delivered or issued for delivery in this State by an insurer, fraternal benefit society, voluntary health service plan, or health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or a policy issued under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), or any similar organization, that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare.

(d) "Issuer" includes insurance companies, fraternal benefit societies, voluntary health service plans, health maintenance organizations, or any other entity providing Medicare supplement insurance, unless the context clearly indicates otherwise.

(e) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of

1965.

(3) No Medicare supplement insurance policy, contract, or certificate, that provides benefits that duplicate benefits provided by Medicare, shall be issued or issued for delivery in this State after December 31, 1988. No such policy, contract, or certificate shall provide lesser benefits than those required under this Section or the existing Medicare Supplement Minimum Standards Regulation, except where duplication of Medicare benefits would result.

(4) Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded directly to him or her in a timely manner if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(5) A Medicare supplement policy or certificate may not deny a claim for losses incurred more than 6 months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(6) An issuer of a Medicare supplement policy shall:

(a) not deny coverage to an applicant under 65 years of age who meets any of the following criteria:

(i) becomes eligible for Medicare by reason of disability if the person makes application for a Medicare supplement policy within 6 months of the first day on which the person enrolls for benefits under Medicare Part B; for a person who is retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a 6-month period beginning with the month in which the person received notice of retroactive eligibility to enroll;

(ii) has Medicare and an employer group health plan (either primary or secondary to Medicare) that terminates or ceases to provide all such supplemental health benefits;

(iii) is insured by a Medicare Advantage plan that includes a Health Maintenance Organization, a Preferred Provider Organization, and a Private Fee-For-Service or Medicare Select plan and the applicant moves out of the plan's service area; the insurer goes out of business, withdraws from the market, or has its Medicare contract terminated; or the plan violates its contract provisions or is

misrepresented in its marketing; or

(iv) is insured by a Medicare supplement policy and the insurer goes out of business, withdraws from the market, or the insurance company or agents misrepresent the plan and the applicant is without coverage;

(b) make available to persons eligible for Medicare by reason of disability each type of Medicare supplement policy the issuer makes available to persons eligible for Medicare by reason of age;

(c) not charge individuals who become eligible for Medicare by reason of disability and who are under the age of 65 premium rates for any medical supplemental insurance benefit plan offered by the issuer that exceed the issuer's highest rate on the current rate schedule filed with the Division of Insurance for that plan to individuals who are age 65 or older; and

(d) provide the rights granted by items (a) through (d), for 6 months after the effective date of this amendatory Act of the 95th General Assembly, to any person who had enrolled for benefits under Medicare Part B prior to this amendatory Act of the 95th General Assembly who otherwise would have been eligible for coverage under item (a).

(7) The Director shall issue reasonable rules and regulations for the following purposes:

(a) To establish specific standards for policy provisions of Medicare policies and certificates. The standards shall be in accordance with the requirements of this Code. No requirement of this Code relating to minimum required policy benefits, other than the minimum standards contained in this Section and Section 363a, shall apply to Medicare supplement policies and certificates. The standards may cover, but are not limited to the following:

(A) Terms of renewability.

(B) Initial and subsequent terms of eligibility.

(C) Non-duplication of coverage.

(D) Probationary and elimination periods.

(E) Benefit limitations, exceptions and reductions.

(F) Requirements for replacement.

(G) Recurrent conditions.

(H) Definition of terms.

(I) Requirements for issuing rebates or credits to policyholders if the policy's loss ratio does not comply with subsection (7) of Section 363a.

(J) Uniform methodology for the calculating and reporting of loss ratio information.

(K) Assuring public access to loss ratio information of an issuer of Medicare supplement insurance.

(L) Establishing a process for approving or

disapproving proposed premium increases.

(M) Establishing a policy for holding public hearings prior to approval of premium increases.

(N) Establishing standards for Medicare Select policies.

(O) Prohibited policy provisions not otherwise specifically authorized by statute that, in the opinion of the Director, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy or certificate.

(b) To establish minimum standards for benefits and claims payments, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies.

(c) To implement transitional requirements of Medicare supplement insurance benefits and premiums of Medicare supplement policies and certificates to conform to Medicare program revisions.

(8) If an individual is at least 65 years of age but no more than 75 years of age and has an existing Medicare supplement policy, the individual is entitled to an annual open enrollment period lasting 45 days, commencing with the individual's birthday, and the individual may purchase any Medicare supplement policy with the same issuer that offers benefits equal to or lesser than those provided by the

previous coverage. During this open enrollment period, an issuer of a Medicare supplement policy shall not deny or condition the issuance or effectiveness of Medicare supplemental coverage, nor discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or a medical condition of the individual. An issuer shall provide notice of this annual open enrollment period for eligible Medicare supplement policyholders at the time that the application is made for a Medicare supplement policy or certificate. The notice shall be in a form that may be prescribed by the Department.

(9) Without limiting an individual's eligibility under Department rules implementing 42 U.S.C. 1395ss(s)(2)(A), for at least 63 days after the later of the applicant's loss of benefits or the notice of termination of benefits, including a notice of claim denial due to termination of benefits, under the State's medical assistance program under Article V of the Illinois Public Aid Code, an issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate that is offered and is available for issuance to new enrollees by the issuer; shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and shall not include a policy provision that imposes an exclusion of benefits based on a preexisting condition under such a Medicare supplement

policy if the individual:

(a) is enrolled for Medicare Part B;

(b) was enrolled in the State's medical assistance program during the COVID-19 Public Health Emergency described in Section 5-1.5 of the Illinois Public Aid Code;

(c) was terminated or disenrolled from the State's medical assistance program after the COVID-19 Public Health Emergency and the later of the date of termination of benefits or the date of the notice of termination, including a notice of a claim denial due to termination, occurred on, after, or no more than 63 days before the end of either, as applicable:

(A) the individual's Medicare supplement open enrollment period described in Department rules implementing 42 U.S.C. 1395ss(s)(2)(A); or

(B) the 6-month period described in Section 363(6)(a)(i) of this Code; and

(d) submits evidence of the date of termination of benefits or notice of termination under the State's medical assistance program with the application for a Medicare supplement policy or certificate.

(10) Each Medicare supplement policy and certificate available from an insurer on and after the effective date of this amendatory Act of the 103rd General Assembly shall be made available to all applicants who qualify under

subparagraph (i) of paragraph (a) of subsection (6) or Department rules implementing 42 U.S.C. 1395ss(s)(2)(A) without regard to age or applicability of a Medicare Part B late enrollment penalty.

(Source: P.A. 102-142, eff. 1-1-22.)

ARTICLE 135.

Section 135-5. The Illinois Public Aid Code is amended by adding Section 5-49 as follows:

(305 ILCS 5/5-49 new)

Sec. 5-49. Long-acting reversible contraception. Subject to federal approval, the Department shall adopt policies and rates for long-acting reversible contraception by January 1, 2024 to ensure that reimbursement is not reduced by 4.4% below list price. The Department shall submit any necessary application to the federal Centers for Medicare and Medicaid Services for the purposes of implementing such policies and rates.

ARTICLE 140.

Section 140-5. The Illinois Public Aid Code is amended by changing Section 5-30.8 as follows:

(305 ILCS 5/5-30.8)

Sec. 5-30.8. Managed care organization rate transparency.

(a) For the establishment of managed care organization (MCO) capitation base rate payments from the State, including, but not limited to: (i) hospital fee schedule reforms and updates, (ii) rates related to a single State-mandated preferred drug list, (iii) rate updates related to the State's preferred drug list, (iv) inclusion of coverage for children with special needs, (v) inclusion of coverage for children within the child welfare system, (vi) annual MCO capitation rates, and (vii) any retroactive provider fee schedule adjustments or other changes required by legislation or other actions, the Department of Healthcare and Family Services shall implement a capitation base rate setting process beginning on July 27, 2018 (the effective date of Public Act 100-646) which shall include all of the following elements of transparency:

(1) The Department shall include participating MCOs and a statewide trade association representing a majority of participating MCOs in meetings to discuss the impact to base capitation rates as a result of any new or updated hospital fee schedules or other provider fee schedules. Additionally, the Department shall share any data or reports used to develop MCO capitation rates with participating MCOs. This data shall be comprehensive enough for MCO actuaries to recreate and verify the

accuracy of the capitation base rate build-up.

(2) The Department shall not limit the number of experts that each MCO is allowed to bring to the draft capitation base rate meeting or the final capitation base rate review meeting. Draft and final capitation base rate review meetings shall be held in at least 2 locations.

(3) The Department and its contracted actuary shall meet with all participating MCOs simultaneously and together along with consulting actuaries contracted with statewide trade association representing a majority of Medicaid health plans at the request of the plans. Participating MCOs shall additionally, at their request, be granted individual capitation rate development meetings with the Department.

(4) (Blank). ~~Any quality incentive or other incentive withholding of any portion of the actuarially certified capitation rates must be budget neutral. The entirety of any aggregate withheld amounts must be returned to the MCOs in proportion to their performance on the relevant performance metric. No amounts shall be returned to the Department if all performance measures are not achieved to the extent allowable by federal law and regulations.~~

(4.5) Effective for calendar year 2024, a quality withhold program may be established by the Department for the HealthChoice Illinois Managed Care Program or any successor program. If such program withholds a portion of

the actuarially certified capitation rates, the program must meet the following criteria: (i) benchmarks must be discussed publicly, based on predetermined quality standards that align with the Department's federally approved quality strategy, and set by publication on the Department's website at least 4 months prior to the start of the calendar year; (ii) incentive measures and benchmarks must be reasonable and attainable within the measurement year; and (iii) no less than 75% of the metrics shall be tied to nationally recognized measures. Any non-nationally recognized measures shall be in the reporting category for at least 2 years of experience and evaluation for consistency among MCOs prior to setting a performance baseline. The Department shall provide MCOs with biannual industry average data on the quality withhold measures. If all the money withheld is not earned back by individual MCOs, the Department shall reallocate unearned funds among the MCOs in one or both of the following manners: based upon their quality performance or for quality and equity improvement projects. Nothing in this paragraph prohibits the Department and the MCOs from establishing any other quality performance program.

(5) Upon request, the Department shall provide written responses to questions regarding MCO capitation base rates, the capitation base development methodology, and MCO capitation rate data, and all other requests regarding

capitation rates from MCOs. Upon request, the Department shall also provide to the MCOs materials used in incorporating provider fee schedules into base capitation rates.

(b) For the development of capitation base rates for new capitation rate years:

(1) The Department shall take into account emerging experience in the development of the annual MCO capitation base rates, including, but not limited to, current-year cost and utilization trends observed by MCOs in an actuarially sound manner and in accordance with federal law and regulations.

(2) No later than January 1 of each year, the Department shall release an agreed upon annual calendar that outlines dates for capitation rate setting meetings for that year. The calendar shall include at least the following meetings and deadlines:

(A) An initial meeting for the Department to review MCO data and draft rate assumptions to be used in the development of capitation base rates for the following year.

(B) A draft rate meeting after the Department provides the MCOs with the draft capitation base rates to discuss, review, and seek feedback regarding the draft capitation base rates.

(3) Prior to the submission of final capitation rates

to the federal Centers for Medicare and Medicaid Services, the Department shall provide the MCOs with a final actuarial report including the final capitation base rates for the following year and subsequently conduct a final capitation base review meeting. Final capitation rates shall be marked final.

(c) For the development of capitation base rates reflecting policy changes:

(1) Unless contrary to federal law and regulation, the Department must provide notice to MCOs of any significant operational policy change no later than 60 days prior to the effective date of an operational policy change in order to give MCOs time to prepare for and implement the operational policy change and to ensure that the quality and delivery of enrollee health care is not disrupted. "Operational policy change" means a change to operational requirements such as reporting formats, encounter submission definitional changes, or required provider interfaces made at the sole discretion of the Department and not required by legislation with a retroactive effective date. Nothing in this Section shall be construed as a requirement to delay or prohibit implementation of policy changes that impact enrollee benefits as determined in the sole discretion of the Department.

(2) No later than 60 days after the effective date of the policy change or program implementation, the

Department shall meet with the MCOs regarding the initial data collection needed to establish capitation base rates for the policy change. Additionally, the Department shall share with the participating MCOs what other data is needed to estimate the change and the processes for collection of that data that shall be utilized to develop capitation base rates.

(3) No later than 60 days after the effective date of the policy change or program implementation, the Department shall meet with MCOs to review data and the Department's written draft assumptions to be used in development of capitation base rates for the policy change, and shall provide opportunities for questions to be asked and answered.

(4) No later than 60 days after the effective date of the policy change or program implementation, the Department shall provide the MCOs with draft capitation base rates and shall also conduct a draft capitation base rate meeting with MCOs to discuss, review, and seek feedback regarding the draft capitation base rates.

(d) For the development of capitation base rates for retroactive policy or fee schedule changes:

(1) The Department shall meet with the MCOs regarding the initial data collection needed to establish capitation base rates for the policy change. Additionally, the Department shall share with the participating MCOs what

other data is needed to estimate the change and the processes for collection of the data that shall be utilized to develop capitation base rates.

(2) The Department shall meet with MCOs to review data and the Department's written draft assumptions to be used in development of capitation base rates for the policy change. The Department shall provide opportunities for questions to be asked and answered.

(3) The Department shall provide the MCOs with draft capitation rates and shall also conduct a draft rate meeting with MCOs to discuss, review, and seek feedback regarding the draft capitation base rates.

(4) The Department shall inform MCOs no less than quarterly of upcoming benefit and policy changes to the Medicaid program.

(e) Meetings of the group established to discuss Medicaid capitation rates under this Section shall be closed to the public and shall not be subject to the Open Meetings Act. Records and information produced by the group established to discuss Medicaid capitation rates under this Section shall be confidential and not subject to the Freedom of Information Act.

(Source: P.A. 100-646, eff. 7-27-18; 101-81, eff. 7-12-19.)

ARTICLE 145.

Section 145-5. The Medical Practice Act of 1987 is amended by changing Section 54.2 and by adding Section 15.5 as follows:

(225 ILCS 60/15.5 new)

Sec. 15.5. International medical graduate physicians; licensure. After January 1, 2025, an international medical graduate physician may apply to the Department for a limited license. The Department shall adopt rules establishing qualifications and application fees for the limited licensure of international medical graduate physicians and may adopt other rules as may be necessary for the implementation of this Section. The Department shall adopt rules that provide a pathway to full licensure for limited license holders after the licensee successfully completes a supervision period and satisfies other qualifications as established by the Department.

(225 ILCS 60/54.2)

(Section scheduled to be repealed on January 1, 2027)

Sec. 54.2. Physician delegation of authority.

(a) Nothing in this Act shall be construed to limit the delegation of patient care tasks or duties by a physician, to a licensed practical nurse, a registered professional nurse, or other licensed person practicing within the scope of his or her individual licensing Act. Delegation by a physician

licensed to practice medicine in all its branches to physician assistants or advanced practice registered nurses is also addressed in Section 54.5 of this Act. No physician may delegate any patient care task or duty that is statutorily or by rule mandated to be performed by a physician.

(b) In an office or practice setting and within a physician-patient relationship, a physician may delegate patient care tasks or duties to an unlicensed person who possesses appropriate training and experience provided a health care professional, who is practicing within the scope of such licensed professional's individual licensing Act, is on site to provide assistance.

(c) Any such patient care task or duty delegated to a licensed or unlicensed person must be within the scope of practice, education, training, or experience of the delegating physician and within the context of a physician-patient relationship.

(d) Nothing in this Section shall be construed to affect referrals for professional services required by law.

(e) The Department shall have the authority to promulgate rules concerning a physician's delegation, including but not limited to, the use of light emitting devices for patient care or treatment.

(f) Nothing in this Act shall be construed to limit the method of delegation that may be authorized by any means, including, but not limited to, oral, written, electronic,

standing orders, protocols, guidelines, or verbal orders.

(g) A physician licensed to practice medicine in all of its branches under this Act may delegate any and all authority prescribed to him or her by law to international medical graduate physicians, so long as the tasks or duties are within the scope of practice, education, training, or experience of the delegating physician who is on site to provide assistance. An international medical graduate working in Illinois pursuant to this subsection is subject to all statutory and regulatory requirements of this Act, as applicable, relating to the standards of care. An international medical graduate physician is limited to providing treatment under the supervision of a physician licensed to practice medicine in all of its branches. The supervising physician or employer must keep record of and make available upon request by the Department the following: (1) evidence of education certified by the Educational Commission for Foreign Medical Graduates; (2) evidence of passage of Step 1, Step 2 Clinical Knowledge, and Step 3 of the United States Medical Licensing Examination as required by this Act; and (3) evidence of an unencumbered license from another country. This subsection does not apply to any international medical graduate whose license as a physician is revoked, suspended, or otherwise encumbered. <u>This subsection is inoperative upon the adoption of rules implementing Section 15.5.</u>

(Source: P.A. 103-1, eff. 4-27-23.)

ARTICLE 150.

Section 150-5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.37 as follows:

(5 ILCS 100/5-45.37 new)

Sec. 5-45.37. Emergency rulemaking; medical services for certain noncitizens. To provide for the expeditious and effective ongoing implementation of Section 12-4.35 of the Illinois Public Aid Code, emergency rules implementing Section 12-4.35 of the Illinois Public Aid Code may be adopted in accordance with Section 5-45 by the Department of Healthcare and Family Services, except that the limitation on the number of emergency rules that may be adopted in a 24-month period shall not apply. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed 2 years after the effective date of this amendatory Act of the 103rd General Assembly.

Section 150-10. The Illinois Public Aid Code is amended by changing Section 12-4.35 as follows:

(305 ILCS 5/12-4.35)

Sec. 12-4.35. Medical services for certain noncitizens.

(a) Notwithstanding Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act, the Department of Healthcare and Family Services may provide medical services to noncitizens who have not yet attained 19 years of age and who are not eligible for medical assistance under Article V of this Code or under the Children's Health Insurance Program created by the Children's Health Insurance Program Act due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code or the Children's Health Insurance Program created by the Children's Health Insurance Program Act.

(a-5) Notwithstanding Section 1-11 of this Code, the Department of Healthcare and Family Services may provide medical assistance in accordance with Article V of this Code to noncitizens over the age of 65 years of age who are not eligible for medical assistance under Article V of this Code due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code, whose income is at or below 100% of the federal poverty level after deducting the costs of medical or other remedial care, and who would otherwise meet the eligibility requirements in Section 5-2 of this Code. The

medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code.

(a-6) By May 30, 2022, notwithstanding Section 1-11 of this Code, the Department of Healthcare and Family Services may provide medical services to noncitizens 55 years of age through 64 years of age who (i) are not eligible for medical assistance under Article V of this Code due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code and (ii) have income at or below 133% of the federal poverty level plus 5% for the applicable family size as determined under applicable federal law and regulations. Persons eligible for medical services under Public Act 102-16 shall receive benefits identical to the benefits provided under the Health Benefits Service Package as that term is defined in subsection (m) of Section 5-1.1 of this Code.

(a-7) By July 1, 2022, notwithstanding Section 1-11 of this Code, the Department of Healthcare and Family Services may provide medical services to noncitizens 42 years of age through 54 years of age who (i) are not eligible for medical assistance under Article V of this Code due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code and (ii) have income at or below 133% of the federal poverty level plus 5% for the applicable family size as

determined under applicable federal law and regulations. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code. In order to provide for the timely and expeditious implementation of this subsection, the Department may adopt rules necessary to establish and implement this subsection through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of the Illinois Administrative Procedure Act, the General Assembly finds that the adoption of rules to implement this subsection is deemed necessary for the public interest, safety, and welfare.

(a-10) Notwithstanding the provisions of Section 1-11, the Department shall cover immunosuppressive drugs and related services associated with post-kidney transplant management, excluding long-term care costs, for noncitizens who: (i) are not eligible for comprehensive medical benefits; (ii) meet the residency requirements of Section 5-3; and (iii) would meet the financial eligibility requirements of Section 5-2.

(b) The Department is authorized to take any action that would not otherwise be prohibited by applicable law, including, without limitation, cessation or limitation of enrollment, reduction of available medical services, and

changing standards for eligibility, that is deemed necessary by the Department during a State fiscal year to assure that payments under this Section do not exceed available funds.

(c) (Blank).

(d) (Blank).

(e) In order to provide for the expeditious and effective ongoing implementation of this Section, the Department may adopt rules through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act, except that the limitation on the number of emergency rules that may be adopted in a 24-month period shall not apply. For purposes of the Illinois Administrative Procedure Act, the General Assembly finds that the adoption of rules to implement this Section is deemed necessary for the public interest, safety, and welfare. This subsection (e) is inoperative on and after July 1, 2025.

(Source: P.A. 101-636, eff. 6-10-20; 102-16, eff. 6-17-21; 102-43, Article 25, Section 25-15, eff. 7-6-21; 102-43, Article 45, Section 45-5, eff. 7-6-21; 102-813, eff. 5-13-22; 102-1037, eff. 6-2-22.)

ARTICLE 999.

Section 999-99. Effective date. This Article and Articles 1, 5, 10, 130, 145, and 150 take effect upon becoming law and Articles 65, 115, 120, and 135 take effect July 1, 2023.