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1 AMENDMENT TO SENATE BILL 1298

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

4 "ARTICLE 1.

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

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

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

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

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

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

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

3 (5 ILCS 100/5-45.35 new)

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

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

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

19 (20 ILCS 301/55-30)

20 Sec. 55-30. Rate increase.

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

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

9 (b) (Blank).

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

15 (1) Admission and Discharge Assessment.

16 (2) Level 1 (Individual).

17 (3) Level 1 (Group).

18 (4) Level 2 (Individual).

19 (5) Level 2 (Group).

20 (6) Case Management.

21 (7) Psychiatric Evaluation.

22 (8) Medication Assisted Recovery.

23 (9) Community Intervention.

24 (10) Early Intervention (Individual).

25 (11) Early Intervention (Group).

26 Beginning in State Fiscal Year 2023, and every State

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

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

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

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

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

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

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

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

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

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

11 (305 ILCS 5/5-47 new)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 ARTICLE 10.

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

22 (5 ILCS 100/5-45.36 new)

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

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

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

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

18 (305 ILCS 5/5-5.05)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 ~~Illinois.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 ~~Illinois.~~

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

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

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

20 ~~Illinois.~~

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

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

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

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

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

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

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

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

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

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

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

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

5 (305 ILCS 5/5A-12.7)

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

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

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

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

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

6 (c) Graduate medical education.

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

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

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

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

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

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

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

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

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

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

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

1 Enterprise Data Warehouse as of May 11, 2020.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 administrative rules:

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

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

16 (C) Long term acute care hospitals.

17 (D) Freestanding psychiatric hospitals.

18 (E) Freestanding rehabilitation hospitals.

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

24 (G) High Medicaid hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 first day of each Payout Quarter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 Definitions. As used in this subsection:

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

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

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

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

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

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

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

22 (j) Pass-through payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 hospitals.

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

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

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

14 (305 ILCS 5/12-4.105)

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

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

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

7 (305 ILCS 5/14-12)

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

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

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

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

1 prior to their effective date.

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

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

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

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

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

8 (7.5) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (2) Phase 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (F) Entities eligible to be funded.

26 (i) Proposals for funding should come from

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (x) Documentation of a community input process

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

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

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

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

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

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

26 (H) The Department shall evaluate proposals for

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

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

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

21 (3) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (305 ILCS 5/14-12.5 new)

23 Sec. 14-12.5. Hospital rate updates.

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

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

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

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

11 (2) For inpatient psychiatric services:

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

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

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

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

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

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

1 shall be increased by 10%.

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (305 ILCS 5/14-12.7 new)

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

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

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

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

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

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

10 ARTICLE 15.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 medical assistance under this Article, as follows:

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

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

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

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

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

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

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

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

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

10 For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the conditional enrollment period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (305 ILCS 5/5-5.01a)

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

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

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

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

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

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

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

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

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

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

5 Subject to federal approval, beginning January 1, 2024,
6 the dementia care rate for supportive living services must be
7 no less than the non-dementia care supportive living services
8 rate multiplied by 1.5.

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

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

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

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

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

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

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

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

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

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

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

11 ARTICLE 25.

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

14 (305 ILCS 5/12-4.57 new)

15 Sec. 12-4.57. Prospective Payment System rates; increase
16 for federally qualified health centers. Beginning January 1,
17 2024, subject to federal approval, the Department of
18 Healthcare and Family Services shall increase the Prospective
19 Payment System rates for federally qualified health centers to
20 a level calculated to spend an additional \$50,000,000 in the
21 first year of application using an alternative payment method
22 acceptable to the Centers for Medicare and Medicaid Services
23 and a trade association representing a majority of federally

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

4 ARTICLE 30.

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

7 (210 ILCS 49/5-107)

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

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

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

21 ARTICLE 35.

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

1 (305 ILCS 5/5-2b)

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

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

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

1 20% higher than the reimbursement rates in effect for nursing
2 services on December 31, 2023.

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

4 ARTICLE 40.

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

7 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

8 Sec. 5-5.2. Payment.

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

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

15 (c) (Blank).

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

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

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

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

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

1 preceding the rate period based upon the Assessment
2 Reference Date of the Minimum Data Set (MDS).

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

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

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

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

1 Facilities with at least 70% of the staffing indicated
2 by the STRIVE study shall be paid a per diem add-on of \$9,
3 increasing by equivalent steps for each whole percentage
4 point until the facilities reach a per diem of \$14.88.
5 Facilities with at least 80% of the staffing indicated by
6 the STRIVE study shall be paid a per diem add-on of \$14.88,
7 increasing by equivalent steps for each whole percentage
8 point until the facilities reach a per diem add-on of
9 \$23.80. Facilities with at least 92% of the staffing
10 indicated by the STRIVE study shall be paid a per diem
11 add-on of \$23.80, increasing by equivalent steps for each
12 whole percentage point until the facilities reach a per
13 diem add-on of \$29.75. Facilities with at least 100% of
14 the staffing indicated by the STRIVE study shall be paid a
15 per diem add-on of \$29.75, increasing by equivalent steps
16 for each whole percentage point until the facilities reach
17 a per diem add-on of \$35.70. Facilities with at least 110%
18 of the staffing indicated by the STRIVE study shall be
19 paid a per diem add-on of \$35.70, increasing by equivalent
20 steps for each whole percentage point until the facilities
21 reach a per diem add-on of \$38.68. Facilities with at
22 least 125% or higher of the staffing indicated by the
23 STRIVE study shall be paid a per diem add-on of \$38.68.
24 Beginning April 1, 2023, no nursing facility's variable
25 staffing per diem add-on shall be reduced by more than 5%
26 in 2 consecutive quarters. For the quarters beginning July

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

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

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

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

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

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

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

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

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

15 (1) Base rate spending pool shall be:

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

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

23 (C) Thirteen million is added to the product of
24 subparagraph (A) and subparagraph (B) to adjust for
25 the exclusion of nursing homes defined in paragraph
26 (5).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (e-1) (Blank).

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

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

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

17 (f) (Blank).

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

23 (1) (Blank);

24 (2) (Blank);

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

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

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

15 (i-1) Subject to federal approval, on and after January 1,
16 2024, the reimbursement rates for the support component of the
17 nursing facility rate for facilities licensed under the
18 Nursing Home Care Act as skilled or intermediate care
19 facilities shall be the rate in effect on June 30, 2023
20 increased by 12%.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (m) The Department shall work with nursing facility

1 industry representatives to design policies and procedures to
2 permit facilities to address the integrity of data from
3 federal reporting sites used by the Department in setting
4 facility rates.

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

8 ARTICLE 45.

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

11 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

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

23 (a) (blank);

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

20 The Department shall establish eligibility standards for

21 such services. In determining the amount and nature of

22 services for which a person may qualify, consideration shall

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

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

25 agreement dividing marital property into equal but separate

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

1 home to his spouse, provided that the spouse's share of the
2 marital property is not made available to the person seeking
3 such services.

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

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

1 the determination be appealed at any time during the 45 day
2 notice period. The target population identified for the
3 purposes of this Section are persons age 60 and older with an
4 identified service need. Priority shall be given to those who
5 are at imminent risk of institutionalization. The services
6 shall be provided to eligible persons age 60 and older to the
7 extent that the cost of the services together with the other
8 personal maintenance expenses of the persons are reasonably
9 related to the standards established for care in a group
10 facility appropriate to the person's condition. These
11 non-institutional services, pilot projects or experimental
12 facilities may be provided as part of or in addition to those
13 authorized by federal law or those funded and administered by
14 the Department of Human Services. The Departments of Human
15 Services, Healthcare and Family Services, Public Health,
16 Veterans' Affairs, and Commerce and Economic Opportunity and
17 other appropriate agencies of State, federal and local
18 governments shall cooperate with the Department on Aging in
19 the establishment and development of the non-institutional
20 services. The Department shall require an annual audit from
21 all personal assistant and home care aide vendors contracting
22 with the Department under this Section. The annual audit shall
23 assure that each audited vendor's procedures are in compliance
24 with Department's financial reporting guidelines requiring an
25 administrative and employee wage and benefits cost split as
26 defined in administrative rules. The audit is a public record

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

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

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

1 necessary to reflect any change in the officially designated
2 federal poverty standard.

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

1 from the deceased spouse's estate. "Homestead", as used in
2 this paragraph, means the dwelling house and contiguous real
3 estate occupied by a surviving spouse or relative, as defined
4 by the rules and regulations of the Department of Healthcare
5 and Family Services, regardless of the value of the property.

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

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

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

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

22 (4) ensuring that the determination of need tool is
23 accurate in determining the participants' level of need;
24 to achieve this, the Department, in conjunction with the
25 Older Adult Services Advisory Committee, shall institute a
26 study of the relationship between the Determination of

1 Need scores, level of need, service cost maximums, and the
2 development and utilization of service plans no later than
3 May 1, 2008; findings and recommendations shall be
4 presented to the Governor and the General Assembly no
5 later than January 1, 2009; recommendations shall include
6 all needed changes to the service cost maximums schedule
7 and additional covered services;

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

11 (A) bathing;

12 (B) grooming;

13 (C) toileting;

14 (D) nail care;

15 (E) transferring;

16 (F) respiratory services;

17 (G) exercise; or

18 (H) positioning;

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

25 (7) ensuring that the State may access maximum federal
26 matching funds by seeking approval for the Centers for

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

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

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

21 (10) working in conjunction with Care Coordination
22 Units, the Department of Healthcare and Family Services,
23 the Department of Human Services, Community Care Program
24 providers, and other stakeholders to make improvements to
25 the Medicaid claiming processes and the Medicaid
26 enrollment procedures or requirements as needed,

1 including, but not limited to, specific policy changes or
2 rules to improve the up-front enrollment of participants
3 in the Medicaid program and specific policy changes or
4 rules to insure more prompt submission of bills to the
5 federal government to secure maximum federal matching
6 dollars as promptly as possible; the Department on Aging
7 shall have at least 3 meetings with stakeholders by
8 January 1, 2014 in order to address these improvements;

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

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

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

22 By January 1, 2009 or as soon after the end of the Cash and
23 Counseling Demonstration Project as is practicable, the
24 Department may, based on its evaluation of the demonstration
25 project, promulgate rules concerning personal assistant
26 services, to include, but need not be limited to,

1 qualifications, employment screening, rights under fair labor
2 standards, training, fiduciary agent, and supervision
3 requirements. All applicants shall be subject to the
4 provisions of the Health Care Worker Background Check Act.

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

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

1 Department upon request and upon termination of the employer's
2 contract with the Department. In addition, the employing
3 agency is responsible for the issuance of certifications of
4 in-service training completed to their employees.

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

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

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

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

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

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

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

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

1 Those persons previously not required to cost-share and who
2 were required to cost-share effective March 1, 1992, shall
3 continue to meet cost-share requirements on and after July 1,
4 1992. Beginning July 1, 1992, all clients will be required to
5 meet eligibility, cost-share, and other requirements and will
6 have services discontinued or altered when they fail to meet
7 these requirements.

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

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

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

1 The Department shall delay Community Care Program services
2 until an applicant is determined eligible for medical
3 assistance under Article V of the Illinois Public Aid Code (i)
4 beginning August 1, 2013, if the Auditor General has reported
5 that the Department has failed to comply with the reporting
6 requirements of Section 2-27 of the Illinois State Auditing
7 Act; or (ii) beginning June 1, 2014, if the Auditor General has
8 reported that the Department has not undertaken the required
9 actions listed in the report required by subsection (a) of
10 Section 2-27 of the Illinois State Auditing Act.

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

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

23 The Department shall conduct a quarterly review of Care
24 Coordination Unit performance and adherence to service
25 guidelines. The quarterly review shall be reported to the
26 Speaker of the House of Representatives, the Minority Leader

1 of the House of Representatives, the President of the Senate,
2 and the Minority Leader of the Senate. The Department shall
3 collect and report longitudinal data on the performance of
4 each care coordination unit. Nothing in this paragraph shall
5 be construed to require the Department to identify specific
6 care coordination units.

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

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

21 Within 30 days after July 6, 2017 (the effective date of
22 Public Act 100-23), rates shall be increased to \$18.29 per
23 hour, for the purpose of increasing, by at least \$.72 per hour,
24 the wages paid by those vendors to their employees who provide
25 homemaker services. The Department shall pay an enhanced rate
26 under the Community Care Program to those in-home service

1 provider agencies that offer health insurance coverage as a
2 benefit to their direct service worker employees consistent
3 with the mandates of Public Act 95-713. For State fiscal years
4 2018 and 2019, the enhanced rate shall be \$1.77 per hour. The
5 rate shall be adjusted using actuarial analysis based on the
6 cost of care, but shall not be set below \$1.77 per hour. The
7 Department shall adopt rules, including emergency rules under
8 subsections (y) and (bb) of Section 5-45 of the Illinois
9 Administrative Procedure Act, to implement the provisions of
10 this paragraph.

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

23 The General Assembly finds it necessary to authorize an
24 aggressive Medicaid enrollment initiative designed to maximize
25 federal Medicaid funding for the Community Care Program which
26 produces significant savings for the State of Illinois. The

1 Department on Aging shall establish and implement a Community
2 Care Program Medicaid Initiative. Under the Initiative, the
3 Department on Aging shall, at a minimum: (i) provide an
4 enhanced rate to adequately compensate care coordination units
5 to enroll eligible Community Care Program clients into
6 Medicaid; (ii) use recommendations from a stakeholder
7 committee on how best to implement the Initiative; and (iii)
8 establish requirements for State agencies to make enrollment
9 in the State's Medical Assistance program easier for seniors.

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

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

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

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

26 (4) One individual representing a care coordination

1 unit, appointed by the Director of Aging.

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

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

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

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

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

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

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

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

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

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

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

1 eligible for medical assistance benefits but are not enrolled
2 in the State's Medicaid Assistance Program. The data provided
3 to the Subcommittee shall be made available to the public via
4 the Department on Aging's website.

5 The Department on Aging, with the involvement of the
6 Subcommittee, shall collaborate with the Department of Human
7 Services and the Department of Healthcare and Family Services
8 on how best to achieve the responsibilities of the Community
9 Care Program Medicaid Initiative.

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

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

22 The Community Care Program Medicaid Initiative shall
23 provide targeted funding to care coordination units to help
24 seniors complete their applications for medical assistance
25 benefits. On and after July 1, 2019, care coordination units
26 shall receive no less than \$200 per completed application,

1 which rate may be included in a bundled rate for initial intake
2 services when Medicaid application assistance is provided in
3 conjunction with the initial intake process for new program
4 participants.

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

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

10 ARTICLE 50.

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

13 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

14 Sec. 5-5.2. Payment.

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

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

21 (c) (Blank).

22 (c-1) Notwithstanding any other provisions of this Code,
23 the methodologies for reimbursement of nursing services as

1 provided under this Article shall no longer be applicable for
2 bills payable for nursing services rendered on or after a new
3 reimbursement system based on the Patient Driven Payment Model
4 (PDPM) has been fully operationalized, which shall take effect
5 for services provided on or after the implementation of the
6 PDPM reimbursement system begins. For the purposes of this
7 amendatory Act of the 102nd General Assembly, the
8 implementation date of the PDPM reimbursement system and all
9 related provisions shall be July 1, 2022 if the following
10 conditions are met: (i) the Centers for Medicare and Medicaid
11 Services has approved corresponding changes in the
12 reimbursement system and bed assessment; and (ii) the
13 Department has filed rules to implement these changes no later
14 than June 1, 2022. Failure of the Department to file rules to
15 implement the changes provided in this amendatory Act of the
16 102nd General Assembly no later than June 1, 2022 shall result
17 in the implementation date being delayed to October 1, 2022.

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

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

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

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

13 (4) PDPM nursing case mix indices in effect on March
14 1, 2022 shall be assigned to each resident class at no less
15 than 0.7858 of the Centers for Medicare and Medicaid
16 Services PDPM unadjusted case mix values, in effect on
17 March 1, 2022.

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

21 (6) The Department shall establish a variable per diem
22 staffing add-on in accordance with the most recent
23 available federal staffing report, currently the Payroll
24 Based Journal, for the same period of time, and if
25 applicable adjusted for acuity using the same quarter's
26 MDS. The Department shall rely on Payroll Based Journals

1 provided to the Department of Public Health to make a
2 determination of non-submission. If the Department is
3 notified by a facility of missing or inaccurate Payroll
4 Based Journal data or an incorrect calculation of
5 staffing, the Department must make a correction as soon as
6 the error is verified for the applicable quarter.

7 Facilities with at least 70% of the staffing indicated
8 by the STRIVE study shall be paid a per diem add-on of \$9,
9 increasing by equivalent steps for each whole percentage
10 point until the facilities reach a per diem of \$14.88.
11 Facilities with at least 80% of the staffing indicated by
12 the STRIVE study shall be paid a per diem add-on of \$14.88,
13 increasing by equivalent steps for each whole percentage
14 point until the facilities reach a per diem add-on of
15 \$23.80. Facilities with at least 92% of the staffing
16 indicated by the STRIVE study shall be paid a per diem
17 add-on of \$23.80, increasing by equivalent steps for each
18 whole percentage point until the facilities reach a per
19 diem add-on of \$29.75. Facilities with at least 100% of
20 the staffing indicated by the STRIVE study shall be paid a
21 per diem add-on of \$29.75, increasing by equivalent steps
22 for each whole percentage point until the facilities reach
23 a per diem add-on of \$35.70. Facilities with at least 110%
24 of the staffing indicated by the STRIVE study shall be
25 paid a per diem add-on of \$35.70, increasing by equivalent
26 steps for each whole percentage point until the facilities

1 reach a per diem add-on of \$38.68. Facilities with at
2 least 125% or higher of the staffing indicated by the
3 STRIVE study shall be paid a per diem add-on of \$38.68.
4 Beginning April 1, 2023, no nursing facility's variable
5 staffing per diem add-on shall be reduced by more than 5%
6 in 2 consecutive quarters. For the quarters beginning July
7 1, 2022 and October 1, 2022, no facility's variable per
8 diem staffing add-on shall be calculated at a rate lower
9 than 85% of the staffing indicated by the STRIVE study. No
10 facility below 70% of the staffing indicated by the STRIVE
11 study shall receive a variable per diem staffing add-on
12 after December 31, 2022.

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

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

25 (B) for the quarter beginning October 1, 2022, the
26 sum of the RUG-IV nursing component per diem

1 multiplied by 0.80 and the PDPM nursing component per
2 diem multiplied by 0.20;

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

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

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

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

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

21 (1) Base rate spending pool shall be:

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

26 (B) Each facility's nursing component per diem in

1 effect on July 1, 2012 shall be multiplied by
2 subsection (A).

3 (C) Thirteen million is added to the product of
4 subparagraph (A) and subparagraph (B) to adjust for
5 the exclusion of nursing homes defined in paragraph
6 (5).

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

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

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

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

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

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

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

4 (B) on and after July 1, 2014 and until July 1,
5 2022, shall be the amount calculated under
6 subparagraph (A) of this paragraph (3) plus \$1.76; and

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

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

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

20 (e) Beginning July 1, 2014, the Department shall allocate
21 funding in the amount up to \$10,000,000 for per diem add-ons to
22 the RUGS methodology for dates of service on and after July 1,
23 2014:

24 (1) \$0.63 for each resident who scores in I4200
25 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

26 (2) \$2.67 for each resident who scores either a "1" or

1 "2" in any items S1200A through S1200I and also scores in
2 RUG groups PA1, PA2, BA1, or BA2.

3 (e-1) (Blank).

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

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

23 (e-4) Subject to federal approval, on and after January 1,
24 2024, the Department shall increase the rate add-on at
25 paragraph (7) subsection (a) under 89 Ill. Adm. Code 147.335
26 for ventilator services from \$208 per day to \$481 per day.

1 Payment is subject to the criteria and requirements under 89
2 Ill. Adm. Code 147.335.

3 (f) (Blank).

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

9 (1) (Blank);

10 (2) (Blank);

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

13 (h) Notwithstanding any other provision of this Code, on
14 and after July 1, 2012, nursing facilities designated by the
15 Department of Healthcare and Family Services as "Institutions
16 for Mental Disease" and "Institutions for Mental Disease" that
17 are facilities licensed under the Specialized Mental Health
18 Rehabilitation Act of 2013 shall have the nursing,
19 socio-developmental, capital, and support components of their
20 reimbursement rate effective May 1, 2011 reduced in total by
21 2.7%.

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

1 (j) Notwithstanding any other provision of law, subject to
2 federal approval, effective July 1, 2019, sufficient funds
3 shall be allocated for changes to rates for facilities
4 licensed under the Nursing Home Care Act as skilled nursing
5 facilities or intermediate care facilities for dates of
6 services on and after July 1, 2019: (i) to establish, through
7 June 30, 2022 a per diem add-on to the direct care per diem
8 rate not to exceed \$70,000,000 annually in the aggregate
9 taking into account federal matching funds for the purpose of
10 addressing the facility's unique staffing needs, adjusted
11 quarterly and distributed by a weighted formula based on
12 Medicaid bed days on the last day of the second quarter
13 preceding the quarter for which the rate is being adjusted.
14 Beginning July 1, 2022, the annual \$70,000,000 described in
15 the preceding sentence shall be dedicated to the variable per
16 diem add-on for staffing under paragraph (6) of subsection
17 (d); and (ii) in an amount not to exceed \$170,000,000 annually
18 in the aggregate taking into account federal matching funds to
19 permit the support component of the nursing facility rate to
20 be updated as follows:

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

1 Services.

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

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

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

25 (l) The Department shall establish per diem add-on
26 payments to improve the quality of care delivered by

1 facilities, including:

2 (1) Incentive payments determined by facility
3 performance on specified quality measures in an initial
4 amount of \$70,000,000. Nothing in this subsection shall be
5 construed to limit the quality of care payments in the
6 aggregate statewide to \$70,000,000, and, if quality of
7 care has improved across nursing facilities, the
8 Department shall adjust those add-on payments accordingly.
9 The quality payment methodology described in this
10 subsection must be used for at least State Fiscal Year
11 2023. Beginning with the quarter starting July 1, 2023,
12 the Department may add, remove, or change quality metrics
13 and make associated changes to the quality payment
14 methodology as outlined in subparagraph (E). Facilities
15 designated by the Centers for Medicare and Medicaid
16 Services as a special focus facility or a hospital-based
17 nursing home do not qualify for quality payments.

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

23 (B) Star rating weights are assigned based on the
24 nursing home's star rating for the LTS quality star
25 rating. As used in this subparagraph, "LTS quality
26 star rating" means the long-term stay quality rating

1 for each nursing facility, as assigned by the Centers
2 for Medicare and Medicaid Services under the Five-Star
3 Quality Rating System. The rating is a number ranging
4 from 0 (lowest) to 5 (highest).

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

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

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

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

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

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

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

1 Department, the STAR rating assigned to the facility
2 shall be reduced by one from the prior quarter.

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

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

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

22 (2) Payments based on CNA tenure, promotion, and CNA
23 training for the purpose of increasing CNA compensation.
24 It is the intent of this subsection that payments made in
25 accordance with this paragraph be directly incorporated
26 into increased compensation for CNAs. As used in this

1 paragraph, "CNA" means a certified nursing assistant as
2 that term is described in Section 3-206 of the Nursing
3 Home Care Act, Section 3-206 of the ID/DD Community Care
4 Act, and Section 3-206 of the MC/DD Act. The Department
5 shall establish, by rule, payments to nursing facilities
6 equal to Medicaid's share of the tenure wage increments
7 specified in this paragraph for all reported CNA employee
8 hours compensated according to a posted schedule
9 consisting of increments at least as large as those
10 specified in this paragraph. The increments are as
11 follows: an additional \$1.50 per hour for CNAs with at
12 least one and less than 2 years' experience plus another
13 \$1 per hour for each additional year of experience up to a
14 maximum of \$6.50 for CNAs with at least 6 years of
15 experience. For purposes of this paragraph, Medicaid's
16 share shall be the ratio determined by paid Medicaid bed
17 days divided by total bed days for the applicable time
18 period used in the calculation. In addition, and additive
19 to any tenure increments paid as specified in this
20 paragraph, the Department shall establish, by rule,
21 payments supporting Medicaid's share of the
22 promotion-based wage increments for CNA employee hours
23 compensated for that promotion with at least a \$1.50
24 hourly increase. Medicaid's share shall be established as
25 it is for the tenure increments described in this
26 paragraph. Qualifying promotions shall be defined by the

1 Department in rules for an expected 10-15% subset of CNAs
2 assigned intermediate, specialized, or added roles such as
3 CNA trainers, CNA scheduling "captains", and CNA
4 specialists for resident conditions like dementia or
5 memory care or behavioral health.

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

11 (Source: P.A. 101-10, eff. 6-5-19; 101-348, eff. 8-9-19;
12 102-77, eff. 7-9-21; 102-558, eff. 8-20-21; 102-1035, eff.
13 5-31-22; 102-1118, eff. 1-18-23.)

14 ARTICLE 55.

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

17 (305 ILCS 5/5-5i new)

18 Sec. 5-5i. Rate increase for speech, physical, and
19 occupational therapy services. Subject to federal approval,
20 beginning January 1, 2024, the Department shall increase
21 reimbursement rates for speech therapy services, physical
22 therapy services, and occupational therapy services provided
23 by licensed speech-language pathologists and speech-language

1 pathology assistants, physical therapists and physical therapy
2 assistants, and occupational therapists and certified
3 occupational therapy assistants, including those in their
4 clinical fellowship, by 14.2%.

5 ARTICLE 60.

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

8 (305 ILCS 5/5-35.5 new)

9 Sec. 5-35.5. Personal needs allowance; nursing home
10 residents. Subject to federal approval, on and after January
11 1, 2024, for a person who is a resident in a facility licensed
12 under the Nursing Home Care Act for whom payments are made
13 under this Article throughout a month and who is determined to
14 be eligible for medical assistance under this Article, the
15 monthly personal needs allowance shall be \$60.

16 ARTICLE 65.

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

20 (305 ILCS 66/20-10)

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

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

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

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

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

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

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

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

6 (5) Medicaid user-based directed payments.

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

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

26 (ii) As used in this subparagraph, "user"

1 means an individual who received at least 200
2 units of community support team services (H2016)
3 during the base year.

4 (B) For each State fiscal year, a monthly directed
5 payment shall be paid to each community mental health
6 provider of assertive community treatment services
7 based on the number of Medicaid users of assertive
8 community treatment services documented by Medicaid
9 fee-for-service and managed care encounter claims
10 delivered by the provider in the base year.

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

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

23 (C) The base year for directed payments under this
24 Section shall be calendar year 2019 for State Fiscal
25 Year 2023 and State Fiscal Year 2024. For the State
26 fiscal year beginning on July 1, 2024, and for every

1 State fiscal year thereafter, the base year shall be
2 the calendar year that ended 18 months prior to the
3 start of the State fiscal year in which payments are
4 made.

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

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

19 (1) Subject to federal approval, beginning on January
20 1, 2024, the Department shall introduce rate increases to
21 behavioral health services no less than by the following
22 targeted pool for the specified services provided by
23 community mental health centers:

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

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

26 (C) Integrative Assessment and Treatment Planning

1 services, \$10,500,000;

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

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

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

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

6 (2) Rate increases shall be determined with
7 significant input from Illinois behavioral health trade
8 associations and advocates. The Department must use
9 service units delivered under the fee-for-service and
10 managed care programs by community mental health centers
11 during State Fiscal Year 2022. These services are used for
12 distributing the targeted pools and setting rates but do
13 not prohibit the Department from paying providers not
14 enrolled as community mental health centers the same rate
15 if providing the same services.

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

17 (1) The Department shall work with stakeholders to
18 redesign reimbursement rates for behavioral health
19 team-based services established under the Rehabilitation
20 Option of the Illinois Medicaid State Plan supporting
21 individuals with chronic or complex behavioral health
22 conditions and crisis services. Subject to federal
23 approval, the redesigned rates shall seek to introduce
24 bundled payment systems that minimize provider claiming
25 activities while transitioning the focus of treatment
26 towards metrics and outcomes. Federally approved rate

1 models shall seek to ensure reimbursement levels are no
2 less than the State's total reimbursement for similar
3 services in calendar year 2023, including all service
4 level payments, add-ons, and all other payments specified
5 in this Section.

6 (2) In State Fiscal Year 2024, the Department shall
7 identify an existing, or establish a new, Behavioral
8 Health Outcomes Stakeholder Workgroup to help inform the
9 identification of metrics and outcomes for team-based
10 services.

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

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

18 (305 ILCS 66/20-20)

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

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

21 No base Medicaid rate or Medicaid rate add-on payment or
22 any other payment for the provision of Medicaid community
23 mental health services in place on July 1, 2021 shall be
24 diminished or changed to make the reimbursement changes
25 required by this Act. Any payments required under this Act

1 that are delayed due to implementation challenges or federal
2 approval shall be made retroactive to July 1, 2022 for the full
3 amount required by this Act.

4 (b) For directed payments under subsection (b) of Section
5 20-10~~:-~~

6 No base Medicaid rate payment or any other payment for the
7 provision of Medicaid community mental health services in
8 place on January 1, 2023 shall be diminished or changed to make
9 the reimbursement changes required by this Act. The Department
10 of Healthcare and Family Services must pay the directed
11 payment in one installment within 60 days of receiving federal
12 approval.

13 (c) For directed payments under subsection (c) of Section
14 20-10:

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

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

1 (305 ILCS 66/20-22 new)

2 Sec. 20-22. Implementation plan for cost reporting.

3 (a) For the purpose of understanding behavioral health
4 services cost structures and their impact on the Illinois
5 Medical Assistance Program, the Department shall engage
6 stakeholders to develop a plan for the regular collection of
7 cost reporting for all entity-based providers of behavioral
8 health services reimbursed under the Rehabilitation or
9 Prevention authorities of the Illinois Medicaid State Plan.
10 Data shall be used to inform on the effectiveness and
11 efficiency of Illinois Medicaid rates. The plan at minimum
12 should consider the following:

13 (1) alignment with certified community behavioral
14 health clinic requirements, standards, policies, and
15 procedures;

16 (2) inclusion of prospective costs to measure what is
17 needed to increase services and capacity;

18 (3) consideration of differences in collection and
19 policies based on the size of providers;

20 (4) consideration of additional administrative time
21 and costs;

22 (5) goals, purposes, and usage of data collected from
23 cost reports;

24 (6) inclusion of qualitative data in addition to
25 quantitative data;

26 (7) technical assistance for providers for completing

1 cost reports including initial training by the Department
2 for providers; and

3 (8) an implementation timeline that allows an initial
4 grace period for providers to adjust internal procedures
5 and data collection.

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

10 (b) The Department and stakeholders shall develop a plan
11 by April 1, 2024. The Department shall engage stakeholders on
12 implementation of the plan.

13 ARTICLE 70.

14 Section 70-5. The Illinois Public Aid Code is amended by
15 changing Section 5-4.2 as follows:

16 (305 ILCS 5/5-4.2)

17 Sec. 5-4.2. Ambulance services payments.

18 (a) For ambulance services provided to a recipient of aid
19 under this Article on or after January 1, 1993, the Illinois
20 Department shall reimburse ambulance service providers at
21 rates calculated in accordance with this Section. It is the
22 intent of the General Assembly to provide adequate
23 reimbursement for ambulance services so as to ensure adequate

1 access to services for recipients of aid under this Article
2 and to provide appropriate incentives to ambulance service
3 providers to provide services in an efficient and
4 cost-effective manner. Thus, it is the intent of the General
5 Assembly that the Illinois Department implement a
6 reimbursement system for ambulance services that, to the
7 extent practicable and subject to the availability of funds
8 appropriated by the General Assembly for this purpose, is
9 consistent with the payment principles of Medicare. To ensure
10 uniformity between the payment principles of Medicare and
11 Medicaid, the Illinois Department shall follow, to the extent
12 necessary and practicable and subject to the availability of
13 funds appropriated by the General Assembly for this purpose,
14 the statutes, laws, regulations, policies, procedures,
15 principles, definitions, guidelines, and manuals used to
16 determine the amounts paid to ambulance service providers
17 under Title XVIII of the Social Security Act (Medicare).

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

25 (c) For purposes of this Section, "ambulance services"
26 includes medical transportation services provided by means of

1 an ambulance, air ambulance, medi-car, service car, or taxi.

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

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

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

24 (c-4) For purposes of this Section, "service car" means
25 transportation services provided to a patient by a passenger
26 vehicle where that patient does not require the specialized

1 modes described in subsection (c-1) or (c-3).

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

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

10 (e) Beginning with services rendered on or after July 1,
11 2008, all providers of non-emergency medi-car and service car
12 transportation must certify that the driver and employee
13 attendant, as applicable, have completed a safety program
14 approved by the Department to protect both the patient and the
15 driver, prior to transporting a patient. The provider must
16 maintain this certification in its records. The provider shall
17 produce such documentation upon demand by the Department or
18 its representative. Failure to produce documentation of such
19 training shall result in recovery of any payments made by the
20 Department for services rendered by a non-certified driver or
21 employee attendant. Medi-car and service car providers must
22 maintain legible documentation in their records of the driver
23 and, as applicable, employee attendant that actually
24 transported the patient. Providers must recertify all drivers
25 and employee attendants every 3 years. If they meet the
26 established training components set forth by the Department,

1 providers of non-emergency medi-car and service car
2 transportation that are either directly or through an
3 affiliated company licensed by the Department of Public Health
4 shall be approved by the Department to have in-house safety
5 programs for training their own staff.

6 Notwithstanding the requirements above, any public
7 transportation provider of medi-car and service car
8 transportation that receives federal funding under 49 U.S.C.
9 5307 and 5311 need not certify its drivers and employee
10 attendants under this Section, since safety training is
11 already federally mandated.

12 (f) With respect to any policy or program administered by
13 the Department or its agent regarding approval of
14 non-emergency medical transportation by ground ambulance
15 service providers, including, but not limited to, the
16 Non-Emergency Transportation Services Prior Approval Program
17 (NETSPAP), the Department shall establish by rule a process by
18 which ground ambulance service providers of non-emergency
19 medical transportation may appeal any decision by the
20 Department or its agent for which no denial was received prior
21 to the time of transport that either (i) denies a request for
22 approval for payment of non-emergency transportation by means
23 of ground ambulance service or (ii) grants a request for
24 approval of non-emergency transportation by means of ground
25 ambulance service at a level of service that entitles the
26 ground ambulance service provider to a lower level of

1 compensation from the Department than the ground ambulance
2 service provider would have received as compensation for the
3 level of service requested. The rule shall be filed by
4 December 15, 2012 and shall provide that, for any decision
5 rendered by the Department or its agent on or after the date
6 the rule takes effect, the ground ambulance service provider
7 shall have 60 days from the date the decision is received to
8 file an appeal. The rule established by the Department shall
9 be, insofar as is practical, consistent with the Illinois
10 Administrative Procedure Act. The Director's decision on an
11 appeal under this Section shall be a final administrative
12 decision subject to review under the Administrative Review
13 Law.

14 (f-5) Beginning 90 days after July 20, 2012 (the effective
15 date of Public Act 97-842), (i) no denial of a request for
16 approval for payment of non-emergency transportation by means
17 of ground ambulance service, and (ii) no approval of
18 non-emergency transportation by means of ground ambulance
19 service at a level of service that entitles the ground
20 ambulance service provider to a lower level of compensation
21 from the Department than would have been received at the level
22 of service submitted by the ground ambulance service provider,
23 may be issued by the Department or its agent unless the
24 Department has submitted the criteria for determining the
25 appropriateness of the transport for first notice publication
26 in the Illinois Register pursuant to Section 5-40 of the

1 Illinois Administrative Procedure Act.

2 (f-6) Within 90 days after the effective date of this
3 amendatory Act of the 102nd General Assembly and subject to
4 federal approval, the Department shall file rules to allow for
5 the approval of ground ambulance services when the sole
6 purpose of the transport is for the navigation of stairs or the
7 assisting or lifting of a patient at a medical facility or
8 during a medical appointment in instances where the Department
9 or a contracted Medicaid managed care organization or their
10 transportation broker is unable to secure transportation
11 through any other transportation provider.

12 (f-7) For non-emergency ground ambulance claims properly
13 denied under Department policy at the time the claim is filed
14 due to failure to submit a valid Medical Certification for
15 Non-Emergency Ambulance on and after December 15, 2012 and
16 prior to January 1, 2021, the Department shall allot
17 \$2,000,000 to a pool to reimburse such claims if the provider
18 proves medical necessity for the service by other means.
19 Providers must submit any such denied claims for which they
20 seek compensation to the Department no later than December 31,
21 2021 along with documentation of medical necessity. No later
22 than May 31, 2022, the Department shall determine for which
23 claims medical necessity was established. Such claims for
24 which medical necessity was established shall be paid at the
25 rate in effect at the time of the service, provided the
26 \$2,000,000 is sufficient to pay at those rates. If the pool is

1 not sufficient, claims shall be paid at a uniform percentage
2 of the applicable rate such that the pool of \$2,000,000 is
3 exhausted. The appeal process described in subsection (f)
4 shall not be applicable to the Department's determinations
5 made in accordance with this subsection.

6 (g) Whenever a patient covered by a medical assistance
7 program under this Code or by another medical program
8 administered by the Department, including a patient covered
9 under the State's Medicaid managed care program, is being
10 transported from a facility and requires non-emergency
11 transportation including ground ambulance, medi-car, or
12 service car transportation, a Physician Certification
13 Statement as described in this Section shall be required for
14 each patient. Facilities shall develop procedures for a
15 licensed medical professional to provide a written and signed
16 Physician Certification Statement. The Physician Certification
17 Statement shall specify the level of transportation services
18 needed and complete a medical certification establishing the
19 criteria for approval of non-emergency ambulance
20 transportation, as published by the Department of Healthcare
21 and Family Services, that is met by the patient. This
22 certification shall be completed prior to ordering the
23 transportation service and prior to patient discharge. The
24 Physician Certification Statement is not required prior to
25 transport if a delay in transport can be expected to
26 negatively affect the patient outcome. If the ground ambulance

1 provider, medi-car provider, or service car provider is unable
2 to obtain the required Physician Certification Statement
3 within 10 calendar days following the date of the service, the
4 ground ambulance provider, medi-car provider, or service car
5 provider must document its attempt to obtain the requested
6 certification and may then submit the claim for payment.
7 Acceptable documentation includes a signed return receipt from
8 the U.S. Postal Service, facsimile receipt, email receipt, or
9 other similar service that evidences that the ground ambulance
10 provider, medi-car provider, or service car provider attempted
11 to obtain the required Physician Certification Statement.

12 The medical certification specifying the level and type of
13 non-emergency transportation needed shall be in the form of
14 the Physician Certification Statement on a standardized form
15 prescribed by the Department of Healthcare and Family
16 Services. Within 75 days after July 27, 2018 (the effective
17 date of Public Act 100-646), the Department of Healthcare and
18 Family Services shall develop a standardized form of the
19 Physician Certification Statement specifying the level and
20 type of transportation services needed in consultation with
21 the Department of Public Health, Medicaid managed care
22 organizations, a statewide association representing ambulance
23 providers, a statewide association representing hospitals, 3
24 statewide associations representing nursing homes, and other
25 stakeholders. The Physician Certification Statement shall
26 include, but is not limited to, the criteria necessary to

1 demonstrate medical necessity for the level of transport
2 needed as required by (i) the Department of Healthcare and
3 Family Services and (ii) the federal Centers for Medicare and
4 Medicaid Services as outlined in the Centers for Medicare and
5 Medicaid Services' Medicare Benefit Policy Manual, Pub.
6 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician
7 Certification Statement shall satisfy the obligations of
8 hospitals under Section 6.22 of the Hospital Licensing Act and
9 nursing homes under Section 2-217 of the Nursing Home Care
10 Act. Implementation and acceptance of the Physician
11 Certification Statement shall take place no later than 90 days
12 after the issuance of the Physician Certification Statement by
13 the Department of Healthcare and Family Services.

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

21 Beginning October 1, 2018, the Department of Healthcare
22 and Family Services shall collect data from Medicaid managed
23 care organizations and transportation brokers, including the
24 Department's NETSPAP broker, regarding denials and appeals
25 related to the missing or incomplete Physician Certification
26 Statement forms and overall compliance with this subsection.

1 The Department of Healthcare and Family Services shall publish
2 quarterly results on its website within 15 days following the
3 end of each quarter.

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

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

15 (j) Subject to federal approval, beginning on January 1,
16 2024, the Department shall increase the base rate of
17 reimbursement for both base charges and mileage charges for
18 medical transportation services provided by means of an air
19 ambulance to a level not lower than 50% of the Medicare
20 ambulance fee schedule rates, by designated Medicare locality,
21 in effect on January 1, 2023.

22 (Source: P.A. 101-81, eff. 7-12-19; 101-649, eff. 7-7-20;
23 102-364, eff. 1-1-22; 102-650, eff. 8-27-21; 102-813, eff.
24 5-13-22; 102-1037, eff. 6-2-22.)

1 Section 75-5. The Illinois Public Aid Code is amended by
2 changing Section 5-5.4h as follows:

3 (305 ILCS 5/5-5.4h)

4 Sec. 5-5.4h. Medicaid reimbursement for medically complex
5 for the developmentally disabled facilities licensed under the
6 MC/DD Act.

7 (a) Facilities licensed as medically complex for the
8 developmentally disabled facilities that serve severely and
9 chronically ill patients shall have a specific reimbursement
10 system designed to recognize the characteristics and needs of
11 the patients they serve.

12 (b) For dates of services starting July 1, 2013 and until a
13 new reimbursement system is designed, medically complex for
14 the developmentally disabled facilities that meet the
15 following criteria:

16 (1) serve exceptional care patients; and

17 (2) have 30% or more of their patients receiving
18 ventilator care;

19 shall receive Medicaid reimbursement on a 30-day expedited
20 schedule.

21 (c) Subject to federal approval of changes to the Title
22 XIX State Plan, for dates of services starting July 1, 2014
23 through March 31, 2019, medically complex for the
24 developmentally disabled facilities which meet the criteria in

1 subsection (b) of this Section shall receive a per diem rate
2 for clinically complex residents of \$304. Clinically complex
3 residents on a ventilator shall receive a per diem rate of
4 \$669. Subject to federal approval of changes to the Title XIX
5 State Plan, for dates of services starting April 1, 2019,
6 medically complex for the developmentally disabled facilities
7 must be reimbursed an exceptional care per diem rate, instead
8 of the base rate, for services to residents with complex or
9 extensive medical needs. Exceptional care per diem rates must
10 be paid for the conditions or services specified under
11 subsection (f) at the following per diem rates: Tier 1 \$326,
12 Tier 2 \$546, and Tier 3 \$735. Subject to federal approval, on
13 and after January 1, 2024, each tier rate shall be increased 6%
14 over the amount in effect on the effective date of this
15 amendatory Act of the 103rd General Assembly. Any
16 reimbursement increases applied to the base rate to providers
17 licensed under the ID/DD Community Care Act must also be
18 applied in an equivalent manner to each tier of exceptional
19 care per diem rates for medically complex for the
20 developmentally disabled facilities.

21 (d) For residents on a ventilator pursuant to subsection
22 (c) or subsection (f), facilities shall have a policy
23 documenting their method of routine assessment of a resident's
24 weaning potential with interventions implemented noted in the
25 resident's medical record.

26 (e) For services provided prior to April 1, 2019 and for

1 the purposes of this Section, a resident is considered
2 clinically complex if the resident requires at least one of
3 the following medical services:

4 (1) Tracheostomy care with dependence on mechanical
5 ventilation for a minimum of 6 hours each day.

6 (2) Tracheostomy care requiring suctioning at least
7 every 6 hours, room air mist or oxygen as needed, and
8 dependence on one of the treatment procedures listed under
9 paragraph (4) excluding the procedure listed in
10 subparagraph (A) of paragraph (4).

11 (3) Total parenteral nutrition or other intravenous
12 nutritional support and one of the treatment procedures
13 listed under paragraph (4).

14 (4) The following treatment procedures apply to the
15 conditions in paragraphs (2) and (3) of this subsection:

16 (A) Intermittent suctioning at least every 8 hours
17 and room air mist or oxygen as needed.

18 (B) Continuous intravenous therapy including
19 administration of therapeutic agents necessary for
20 hydration or of intravenous pharmaceuticals; or
21 intravenous pharmaceutical administration of more than
22 one agent via a peripheral or central line, without
23 continuous infusion.

24 (C) Peritoneal dialysis treatments requiring at
25 least 4 exchanges every 24 hours.

26 (D) Tube feeding via nasogastric or gastrostomy

1 tube.

2 (E) Other medical technologies required
3 continuously, which in the opinion of the attending
4 physician require the services of a professional
5 nurse.

6 (f) Complex or extensive medical needs for exceptional
7 care reimbursement. The conditions and services used for the
8 purposes of this Section have the same meanings as ascribed to
9 those conditions and services under the Minimum Data Set (MDS)
10 Resident Assessment Instrument (RAI) and specified in the most
11 recent manual. Instead of submitting minimum data set
12 assessments to the Department, medically complex for the
13 developmentally disabled facilities must document within each
14 resident's medical record the conditions or services using the
15 minimum data set documentation standards and requirements to
16 qualify for exceptional care reimbursement.

17 (1) Tier 1 reimbursement is for residents who are
18 receiving at least 51% of their caloric intake via a
19 feeding tube.

20 (2) Tier 2 reimbursement is for residents who are
21 receiving tracheostomy care without a ventilator.

22 (3) Tier 3 reimbursement is for residents who are
23 receiving tracheostomy care and ventilator care.

24 (g) For dates of services starting April 1, 2019,
25 reimbursement calculations and direct payment for services
26 provided by medically complex for the developmentally disabled

1 facilities are the responsibility of the Department of
2 Healthcare and Family Services instead of the Department of
3 Human Services. Appropriations for medically complex for the
4 developmentally disabled facilities must be shifted from the
5 Department of Human Services to the Department of Healthcare
6 and Family Services. Nothing in this Section prohibits the
7 Department of Healthcare and Family Services from paying more
8 than the rates specified in this Section. The rates in this
9 Section must be interpreted as a minimum amount. Any
10 reimbursement increases applied to providers licensed under
11 the ID/DD Community Care Act must also be applied in an
12 equivalent manner to medically complex for the developmentally
13 disabled facilities.

14 (h) The Department of Healthcare and Family Services shall
15 pay the rates in effect on March 31, 2019 until the changes
16 made to this Section by this amendatory Act of the 100th
17 General Assembly have been approved by the Centers for
18 Medicare and Medicaid Services of the U.S. Department of
19 Health and Human Services.

20 (i) The Department of Healthcare and Family Services may
21 adopt rules as allowed by the Illinois Administrative
22 Procedure Act to implement this Section; however, the
23 requirements of this Section must be implemented by the
24 Department of Healthcare and Family Services even if the
25 Department of Healthcare and Family Services has not adopted
26 rules by the implementation date of April 1, 2019.

1 (Source: P.A. 100-646, eff. 7-27-18.)

2 ARTICLE 80.

3 Section 80-5. The Illinois Public Aid Code is amended by
4 changing Section 5-4.2 as follows:

5 (305 ILCS 5/5-4.2)

6 Sec. 5-4.2. Ambulance services payments.

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

1 necessary and practicable and subject to the availability of
2 funds appropriated by the General Assembly for this purpose,
3 the statutes, laws, regulations, policies, procedures,
4 principles, definitions, guidelines, and manuals used to
5 determine the amounts paid to ambulance service providers
6 under Title XVIII of the Social Security Act (Medicare).

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

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

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

24 (c-2) For purposes of this Section, "ground ambulance
25 service provider" means a vehicle service provider as
26 described in the Emergency Medical Services (EMS) Systems Act

1 that operates licensed ambulances for the purpose of providing
2 emergency ambulance services, or non-emergency ambulance
3 services, or both. For purposes of this Section, this includes
4 both ambulance providers and ambulance suppliers as described
5 by the Centers for Medicare and Medicaid Services.

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

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

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

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

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

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

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

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

24 (f-5) Beginning 90 days after July 20, 2012 (the effective
25 date of Public Act 97-842), (i) no denial of a request for
26 approval for payment of non-emergency transportation by means

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

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

22 (f-7) For non-emergency ground ambulance claims properly
23 denied under Department policy at the time the claim is filed
24 due to failure to submit a valid Medical Certification for
25 Non-Emergency Ambulance on and after December 15, 2012 and
26 prior to January 1, 2021, the Department shall allot

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

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

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

22 The medical certification specifying the level and type of
23 non-emergency transportation needed shall be in the form of
24 the Physician Certification Statement on a standardized form
25 prescribed by the Department of Healthcare and Family
26 Services. Within 75 days after July 27, 2018 (the effective

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

24 Pursuant to subsection (E) of Section 12-4.25 of this
25 Code, the Department is entitled to recover overpayments paid
26 to a provider or vendor, including, but not limited to, from

1 the discharging physician, the discharging facility, and the
2 ground ambulance service provider, in instances where a
3 non-emergency ground ambulance service is rendered as the
4 result of improper or false certification.

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

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

19 (i) Subject to federal approval, on and after January 1,
20 2024 through June 30, 2026, ~~On and after July 1, 2018,~~ the
21 Department shall increase the base rate of reimbursement for
22 both base charges and mileage charges for ground ambulance
23 service providers not participating in the Ground Emergency
24 Medical Transportation (GEMT) Program for medical
25 transportation services provided by means of a ground
26 ambulance to a level not lower than 140% ~~112%~~ of the base rate

1 in effect as of January 1, 2023 ~~June 30, 2018~~.

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

17 (Source: P.A. 101-81, eff. 7-12-19; 101-649, eff. 7-7-20;
18 102-364, eff. 1-1-22; 102-650, eff. 8-27-21; 102-813, eff.
19 5-13-22; 102-1037, eff. 6-2-22.)

20 ARTICLE 85.

21 Section 85-5. The Illinois Act on the Aging is amended by
22 changing Sections 4.02 and 4.06 as follows:

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

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

- 12 (a) (blank);
- 13 (b) (blank);
- 14 (c) home care aide services;
- 15 (d) personal assistant services;
- 16 (e) adult day services;
- 17 (f) home-delivered meals;
- 18 (g) education in self-care;
- 19 (h) personal care services;
- 20 (i) adult day health services;
- 21 (j) habilitation services;
- 22 (k) respite care;
- 23 (k-5) community reintegration services;
- 24 (k-6) flexible senior services;
- 25 (k-7) medication management;
- 26 (k-8) emergency home response;

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

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

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

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

21 The Department shall, in conjunction with the Department
22 of Public Aid (now Department of Healthcare and Family
23 Services), seek appropriate amendments under Sections 1915 and
24 1924 of the Social Security Act. The purpose of the amendments
25 shall be to extend eligibility for home and community based
26 services under Sections 1915 and 1924 of the Social Security

1 Act to persons who transfer to or for the benefit of a spouse
2 those amounts of income and resources allowed under Section
3 1924 of the Social Security Act. Subject to the approval of
4 such amendments, the Department shall extend the provisions of
5 Section 5-4 of the Illinois Public Aid Code to persons who, but
6 for the provision of home or community-based services, would
7 require the level of care provided in an institution, as is
8 provided for in federal law. Those persons no longer found to
9 be eligible for receiving noninstitutional services due to
10 changes in the eligibility criteria shall be given 45 days
11 notice prior to actual termination. Those persons receiving
12 notice of termination may contact the Department and request
13 the determination be appealed at any time during the 45 day
14 notice period. The target population identified for the
15 purposes of this Section are persons age 60 and older with an
16 identified service need. Priority shall be given to those who
17 are at imminent risk of institutionalization. The services
18 shall be provided to eligible persons age 60 and older to the
19 extent that the cost of the services together with the other
20 personal maintenance expenses of the persons are reasonably
21 related to the standards established for care in a group
22 facility appropriate to the person's condition. These
23 non-institutional services, pilot projects or experimental
24 facilities may be provided as part of or in addition to those
25 authorized by federal law or those funded and administered by
26 the Department of Human Services. The Departments of Human

1 Services, Healthcare and Family Services, Public Health,
2 Veterans' Affairs, and Commerce and Economic Opportunity and
3 other appropriate agencies of State, federal and local
4 governments shall cooperate with the Department on Aging in
5 the establishment and development of the non-institutional
6 services. The Department shall require an annual audit from
7 all personal assistant and home care aide vendors contracting
8 with the Department under this Section. The annual audit shall
9 assure that each audited vendor's procedures are in compliance
10 with Department's financial reporting guidelines requiring an
11 administrative and employee wage and benefits cost split as
12 defined in administrative rules. The audit is a public record
13 under the Freedom of Information Act. The Department shall
14 execute, relative to the nursing home prescreening project,
15 written inter-agency agreements with the Department of Human
16 Services and the Department of Healthcare and Family Services,
17 to effect the following: (1) intake procedures and common
18 eligibility criteria for those persons who are receiving
19 non-institutional services; and (2) the establishment and
20 development of non-institutional services in areas of the
21 State where they are not currently available or are
22 undeveloped. On and after July 1, 1996, all nursing home
23 prescreenings for individuals 60 years of age or older shall
24 be conducted by the Department.

25 As part of the Department on Aging's routine training of
26 case managers and case manager supervisors, the Department may

1 include information on family futures planning for persons who
2 are age 60 or older and who are caregivers of their adult
3 children with developmental disabilities. The content of the
4 training shall be at the Department's discretion.

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

15 The Department, or the Department's authorized
16 representative, may recover the amount of moneys expended for
17 services provided to or in behalf of a person under this
18 Section by a claim against the person's estate or against the
19 estate of the person's surviving spouse, but no recovery may
20 be had until after the death of the surviving spouse, if any,
21 and then only at such time when there is no surviving child who
22 is under age 21 or blind or who has a permanent and total
23 disability. This paragraph, however, shall not bar recovery,
24 at the death of the person, of moneys for services provided to
25 the person or in behalf of the person under this Section to
26 which the person was not entitled; provided that such recovery

1 shall not be enforced against any real estate while it is
2 occupied as a homestead by the surviving spouse or other
3 dependent, if no claims by other creditors have been filed
4 against the estate, or, if such claims have been filed, they
5 remain dormant for failure of prosecution or failure of the
6 claimant to compel administration of the estate for the
7 purpose of payment. This paragraph shall not bar recovery from
8 the estate of a spouse, under Sections 1915 and 1924 of the
9 Social Security Act and Section 5-4 of the Illinois Public Aid
10 Code, who precedes a person receiving services under this
11 Section in death. All moneys for services paid to or in behalf
12 of the person under this Section shall be claimed for recovery
13 from the deceased spouse's estate. "Homestead", as used in
14 this paragraph, means the dwelling house and contiguous real
15 estate occupied by a surviving spouse or relative, as defined
16 by the rules and regulations of the Department of Healthcare
17 and Family Services, regardless of the value of the property.

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

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

22 (2) ensuring that care plans contain the services that
23 eligible participants need based on the number of days in
24 a month, not limited to specific blocks of time, as
25 identified by the comprehensive assessment tool selected
26 by the Department for use statewide, not to exceed the

1 total monthly service cost maximum allowed for each
2 service; the Department shall develop administrative rules
3 to implement this item (2);

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

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

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

23 (A) bathing;

24 (B) grooming;

25 (C) toileting;

26 (D) nail care;

1 (E) transferring;

2 (F) respiratory services;

3 (G) exercise; or

4 (H) positioning;

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

11 (7) ensuring that the State may access maximum federal
12 matching funds by seeking approval for the Centers for
13 Medicare and Medicaid Services for modifications to the
14 State's home and community based services waiver and
15 additional waiver opportunities, including applying for
16 enrollment in the Balance Incentive Payment Program by May
17 1, 2013, in order to maximize federal matching funds; this
18 shall include, but not be limited to, modification that
19 reflects all changes in the Community Care Program
20 services and all increases in the services cost maximum;

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

24 (9) ensuring that services are authorized accurately
25 and consistently for the Community Care Program (CCP); the
26 Department shall implement a Service Authorization policy

1 directive; the purpose shall be to ensure that eligibility
2 and services are authorized accurately and consistently in
3 the CCP program; the policy directive shall clarify
4 service authorization guidelines to Care Coordination
5 Units and Community Care Program providers no later than
6 May 1, 2013;

7 (10) working in conjunction with Care Coordination
8 Units, the Department of Healthcare and Family Services,
9 the Department of Human Services, Community Care Program
10 providers, and other stakeholders to make improvements to
11 the Medicaid claiming processes and the Medicaid
12 enrollment procedures or requirements as needed,
13 including, but not limited to, specific policy changes or
14 rules to improve the up-front enrollment of participants
15 in the Medicaid program and specific policy changes or
16 rules to insure more prompt submission of bills to the
17 federal government to secure maximum federal matching
18 dollars as promptly as possible; the Department on Aging
19 shall have at least 3 meetings with stakeholders by
20 January 1, 2014 in order to address these improvements;

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

25 (12) implementing any necessary policy changes or
26 promulgating any rules, no later than January 1, 2014, to

1 assist the Department of Healthcare and Family Services in
2 moving as many participants as possible, consistent with
3 federal regulations, into coordinated care plans if a care
4 coordination plan that covers long term care is available
5 in the recipient's area; and

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

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

17 The Department shall develop procedures to enhance
18 availability of services on evenings, weekends, and on an
19 emergency basis to meet the respite needs of caregivers.
20 Procedures shall be developed to permit the utilization of
21 services in successive blocks of 24 hours up to the monthly
22 maximum established by the Department. Workers providing these
23 services shall be appropriately trained.

24 Beginning on the effective date of this amendatory Act of
25 1991, no person may perform chore/housekeeping and home care
26 aide services under a program authorized by this Section

1 unless that person has been issued a certificate of
2 pre-service to do so by his or her employing agency.
3 Information gathered to effect such certification shall
4 include (i) the person's name, (ii) the date the person was
5 hired by his or her current employer, and (iii) the training,
6 including dates and levels. Persons engaged in the program
7 authorized by this Section before the effective date of this
8 amendatory Act of 1991 shall be issued a certificate of all
9 pre- and in-service training from his or her employer upon
10 submitting the necessary information. The employing agency
11 shall be required to retain records of all staff pre- and
12 in-service training, and shall provide such records to the
13 Department upon request and upon termination of the employer's
14 contract with the Department. In addition, the employing
15 agency is responsible for the issuance of certifications of
16 in-service training completed to their employees.

17 The Department is required to develop a system to ensure
18 that persons working as home care aides and personal
19 assistants receive increases in their wages when the federal
20 minimum wage is increased by requiring vendors to certify that
21 they are meeting the federal minimum wage statute for home
22 care aides and personal assistants. An employer that cannot
23 ensure that the minimum wage increase is being given to home
24 care aides and personal assistants shall be denied any
25 increase in reimbursement costs.

26 The Community Care Program Advisory Committee is created

1 in the Department on Aging. The Director shall appoint
2 individuals to serve in the Committee, who shall serve at
3 their own expense. Members of the Committee must abide by all
4 applicable ethics laws. The Committee shall advise the
5 Department on issues related to the Department's program of
6 services to prevent unnecessary institutionalization. The
7 Committee shall meet on a bi-monthly basis and shall serve to
8 identify and advise the Department on present and potential
9 issues affecting the service delivery network, the program's
10 clients, and the Department and to recommend solution
11 strategies. Persons appointed to the Committee shall be
12 appointed on, but not limited to, their own and their agency's
13 experience with the program, geographic representation, and
14 willingness to serve. The Director shall appoint members to
15 the Committee to represent provider, advocacy, policy
16 research, and other constituencies committed to the delivery
17 of high quality home and community-based services to older
18 adults. Representatives shall be appointed to ensure
19 representation from community care providers including, but
20 not limited to, adult day service providers, homemaker
21 providers, case coordination and case management units,
22 emergency home response providers, statewide trade or labor
23 unions that represent home care aides and direct care staff,
24 area agencies on aging, adults over age 60, membership
25 organizations representing older adults, and other
26 organizational entities, providers of care, or individuals

1 with demonstrated interest and expertise in the field of home
2 and community care as determined by the Director.

3 Nominations may be presented from any agency or State
4 association with interest in the program. The Director, or his
5 or her designee, shall serve as the permanent co-chair of the
6 advisory committee. One other co-chair shall be nominated and
7 approved by the members of the committee on an annual basis.
8 Committee members' terms of appointment shall be for 4 years
9 with one-quarter of the appointees' terms expiring each year.

10 A member shall continue to serve until his or her replacement
11 is named. The Department shall fill vacancies that have a
12 remaining term of over one year, and this replacement shall
13 occur through the annual replacement of expiring terms. The
14 Director shall designate Department staff to provide technical
15 assistance and staff support to the committee. Department
16 representation shall not constitute membership of the
17 committee. All Committee papers, issues, recommendations,
18 reports, and meeting memoranda are advisory only. The
19 Director, or his or her designee, shall make a written report,
20 as requested by the Committee, regarding issues before the
21 Committee.

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

1 each year.

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

8 Those persons previously found eligible for receiving
9 non-institutional services whose services were discontinued
10 under the Emergency Budget Act of Fiscal Year 1992, and who do
11 not meet the eligibility standards in effect on or after July
12 1, 1992, shall remain ineligible on and after July 1, 1992.
13 Those persons previously not required to cost-share and who
14 were required to cost-share effective March 1, 1992, shall
15 continue to meet cost-share requirements on and after July 1,
16 1992. Beginning July 1, 1992, all clients will be required to
17 meet eligibility, cost-share, and other requirements and will
18 have services discontinued or altered when they fail to meet
19 these requirements.

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

25 The Department shall implement an electronic service
26 verification based on global positioning systems or other

1 cost-effective technology for the Community Care Program no
2 later than January 1, 2014.

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

13 The Department shall delay Community Care Program services
14 until an applicant is determined eligible for medical
15 assistance under Article V of the Illinois Public Aid Code (i)
16 beginning August 1, 2013, if the Auditor General has reported
17 that the Department has failed to comply with the reporting
18 requirements of Section 2-27 of the Illinois State Auditing
19 Act; or (ii) beginning June 1, 2014, if the Auditor General has
20 reported that the Department has not undertaken the required
21 actions listed in the report required by subsection (a) of
22 Section 2-27 of the Illinois State Auditing Act.

23 The Department shall implement co-payments for the
24 Community Care Program at the federally allowable maximum
25 level (i) beginning August 1, 2013, if the Auditor General has
26 reported that the Department has failed to comply with the

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

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

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

19 In regard to community care providers, failure to comply
20 with Department on Aging policies shall be cause for
21 disciplinary action, including, but not limited to,
22 disqualification from serving Community Care Program clients.
23 Each provider, upon submission of any bill or invoice to the
24 Department for payment for services rendered, shall include a
25 notarized statement, under penalty of perjury pursuant to
26 Section 1-109 of the Code of Civil Procedure, that the

1 provider has complied with all Department policies.

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

7 Within 30 days after July 6, 2017 (the effective date of
8 Public Act 100-23), rates shall be increased to \$18.29 per
9 hour, for the purpose of increasing, by at least \$.72 per hour,
10 the wages paid by those vendors to their employees who provide
11 homemaker services. The Department shall pay an enhanced rate
12 under the Community Care Program to those in-home service
13 provider agencies that offer health insurance coverage as a
14 benefit to their direct service worker employees consistent
15 with the mandates of Public Act 95-713. For State fiscal years
16 2018 and 2019, the enhanced rate shall be \$1.77 per hour. The
17 rate shall be adjusted using actuarial analysis based on the
18 cost of care, but shall not be set below \$1.77 per hour. The
19 Department shall adopt rules, including emergency rules under
20 subsections (y) and (bb) of Section 5-45 of the Illinois
21 Administrative Procedure Act, to implement the provisions of
22 this paragraph.

23 Subject to federal approval, beginning on January 1, 2024,
24 rates for adult day services shall be increased to \$16.84 per
25 hour and rates for each way transportation services for adult
26 day services shall be increased to \$12.44 per unit

1 transportation.

2 The General Assembly finds it necessary to authorize an
3 aggressive Medicaid enrollment initiative designed to maximize
4 federal Medicaid funding for the Community Care Program which
5 produces significant savings for the State of Illinois. The
6 Department on Aging shall establish and implement a Community
7 Care Program Medicaid Initiative. Under the Initiative, the
8 Department on Aging shall, at a minimum: (i) provide an
9 enhanced rate to adequately compensate care coordination units
10 to enroll eligible Community Care Program clients into
11 Medicaid; (ii) use recommendations from a stakeholder
12 committee on how best to implement the Initiative; and (iii)
13 establish requirements for State agencies to make enrollment
14 in the State's Medical Assistance program easier for seniors.

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

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

26 (2) One representative of the Department of Healthcare

1 and Family Services, appointed by the Director of
2 Healthcare and Family Services.

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

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

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

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

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

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

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

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

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

26 (12) One member of the House of Representatives, who

1 shall serve as co-chairperson, appointed by the Speaker of
2 the House of Representatives.

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

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

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

1 Illinois residents who are not enrolled in the State's Medical
2 Assistance Program but who are eligible for medical assistance
3 benefits. The Department on Aging shall enroll in the State's
4 Medical Assistance Program those Illinois residents who
5 receive services under the Community Care Program and are
6 eligible for medical assistance benefits but are not enrolled
7 in the State's Medicaid Assistance Program. The data provided
8 to the Subcommittee shall be made available to the public via
9 the Department on Aging's website.

10 The Department on Aging, with the involvement of the
11 Subcommittee, shall collaborate with the Department of Human
12 Services and the Department of Healthcare and Family Services
13 on how best to achieve the responsibilities of the Community
14 Care Program Medicaid Initiative.

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

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

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

10 The Community Care Program Medicaid Initiative shall cease
11 operation 5 years after the effective date of this amendatory
12 Act of the 100th General Assembly, after which the
13 Subcommittee shall dissolve.

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

15 (20 ILCS 105/4.06)

16 Sec. 4.06. Coordinated services for minority senior
17 citizens ~~Minority Senior Citizen Program~~. The Department shall
18 develop strategies ~~a program~~ to identify the special needs and
19 problems of minority senior citizens and evaluate the adequacy
20 and accessibility of existing services ~~programs~~ and
21 information for minority senior citizens. The Department shall
22 coordinate services for minority senior citizens through the
23 Department of Public Health, the Department of Healthcare and
24 Family Services, and the Department of Human Services.

25 The Department shall develop procedures to enhance and

1 identify availability of services and shall promulgate
2 administrative rules to establish the responsibilities of the
3 Department.

4 The Department on Aging, the Department of Public Health,
5 the Department of Healthcare and Family Services, and the
6 Department of Human Services shall cooperate in the
7 development and submission of an annual report on ~~programs and~~
8 services provided under this Section. The joint report shall
9 be filed with the Governor and the General Assembly on or
10 before September 30 of each year.

11 (Source: P.A. 95-331, eff. 8-21-07.)

12 ARTICLE 90.

13 Section 90-5. The Illinois Act on the Aging is amended by
14 changing Sections 4.02 and 4.07 as follows:

15 (20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

16 Sec. 4.02. Community Care Program. The Department shall
17 establish a program of services to prevent unnecessary
18 institutionalization of persons age 60 and older in need of
19 long term care or who are established as persons who suffer
20 from Alzheimer's disease or a related disorder under the
21 Alzheimer's Disease Assistance Act, thereby enabling them to
22 remain in their own homes or in other living arrangements.
23 Such preventive services, which may be coordinated with other

1 programs for the aged and monitored by area agencies on aging
2 in cooperation with the Department, may include, but are not
3 limited to, any or all of the following:

4 (a) (blank);

5 (b) (blank);

6 (c) home care aide services;

7 (d) personal assistant services;

8 (e) adult day services;

9 (f) home-delivered meals;

10 (g) education in self-care;

11 (h) personal care services;

12 (i) adult day health services;

13 (j) habilitation services;

14 (k) respite care;

15 (k-5) community reintegration services;

16 (k-6) flexible senior services;

17 (k-7) medication management;

18 (k-8) emergency home response;

19 (l) other nonmedical social services that may enable
20 the person to become self-supporting; or

21 (m) clearinghouse for information provided by senior
22 citizen home owners who want to rent rooms to or share
23 living space with other senior citizens.

24 The Department shall establish eligibility standards for
25 such services. In determining the amount and nature of
26 services for which a person may qualify, consideration shall

1 not be given to the value of cash, property or other assets
2 held in the name of the person's spouse pursuant to a written
3 agreement dividing marital property into equal but separate
4 shares or pursuant to a transfer of the person's interest in a
5 home to his spouse, provided that the spouse's share of the
6 marital property is not made available to the person seeking
7 such services.

8 Beginning January 1, 2008, the Department shall require as
9 a condition of eligibility that all new financially eligible
10 applicants apply for and enroll in medical assistance under
11 Article V of the Illinois Public Aid Code in accordance with
12 rules promulgated by the Department.

13 The Department shall, in conjunction with the Department
14 of Public Aid (now Department of Healthcare and Family
15 Services), seek appropriate amendments under Sections 1915 and
16 1924 of the Social Security Act. The purpose of the amendments
17 shall be to extend eligibility for home and community based
18 services under Sections 1915 and 1924 of the Social Security
19 Act to persons who transfer to or for the benefit of a spouse
20 those amounts of income and resources allowed under Section
21 1924 of the Social Security Act. Subject to the approval of
22 such amendments, the Department shall extend the provisions of
23 Section 5-4 of the Illinois Public Aid Code to persons who, but
24 for the provision of home or community-based services, would
25 require the level of care provided in an institution, as is
26 provided for in federal law. Those persons no longer found to

1 be eligible for receiving noninstitutional services due to
2 changes in the eligibility criteria shall be given 45 days
3 notice prior to actual termination. Those persons receiving
4 notice of termination may contact the Department and request
5 the determination be appealed at any time during the 45 day
6 notice period. The target population identified for the
7 purposes of this Section are persons age 60 and older with an
8 identified service need. Priority shall be given to those who
9 are at imminent risk of institutionalization. The services
10 shall be provided to eligible persons age 60 and older to the
11 extent that the cost of the services together with the other
12 personal maintenance expenses of the persons are reasonably
13 related to the standards established for care in a group
14 facility appropriate to the person's condition. These
15 non-institutional services, pilot projects or experimental
16 facilities may be provided as part of or in addition to those
17 authorized by federal law or those funded and administered by
18 the Department of Human Services. The Departments of Human
19 Services, Healthcare and Family Services, Public Health,
20 Veterans' Affairs, and Commerce and Economic Opportunity and
21 other appropriate agencies of State, federal and local
22 governments shall cooperate with the Department on Aging in
23 the establishment and development of the non-institutional
24 services. The Department shall require an annual audit from
25 all personal assistant and home care aide vendors contracting
26 with the Department under this Section. The annual audit shall

1 assure that each audited vendor's procedures are in compliance
2 with Department's financial reporting guidelines requiring an
3 administrative and employee wage and benefits cost split as
4 defined in administrative rules. The audit is a public record
5 under the Freedom of Information Act. The Department shall
6 execute, relative to the nursing home prescreening project,
7 written inter-agency agreements with the Department of Human
8 Services and the Department of Healthcare and Family Services,
9 to effect the following: (1) intake procedures and common
10 eligibility criteria for those persons who are receiving
11 non-institutional services; and (2) the establishment and
12 development of non-institutional services in areas of the
13 State where they are not currently available or are
14 undeveloped. On and after July 1, 1996, all nursing home
15 prescreenings for individuals 60 years of age or older shall
16 be conducted by the Department.

17 As part of the Department on Aging's routine training of
18 case managers and case manager supervisors, the Department may
19 include information on family futures planning for persons who
20 are age 60 or older and who are caregivers of their adult
21 children with developmental disabilities. The content of the
22 training shall be at the Department's discretion.

23 The Department is authorized to establish a system of
24 recipient copayment for services provided under this Section,
25 such copayment to be based upon the recipient's ability to pay
26 but in no case to exceed the actual cost of the services

1 provided. Additionally, any portion of a person's income which
2 is equal to or less than the federal poverty standard shall not
3 be considered by the Department in determining the copayment.
4 The level of such copayment shall be adjusted whenever
5 necessary to reflect any change in the officially designated
6 federal poverty standard.

7 The Department, or the Department's authorized
8 representative, may recover the amount of moneys expended for
9 services provided to or in behalf of a person under this
10 Section by a claim against the person's estate or against the
11 estate of the person's surviving spouse, but no recovery may
12 be had until after the death of the surviving spouse, if any,
13 and then only at such time when there is no surviving child who
14 is under age 21 or blind or who has a permanent and total
15 disability. This paragraph, however, shall not bar recovery,
16 at the death of the person, of moneys for services provided to
17 the person or in behalf of the person under this Section to
18 which the person was not entitled; provided that such recovery
19 shall not be enforced against any real estate while it is
20 occupied as a homestead by the surviving spouse or other
21 dependent, if no claims by other creditors have been filed
22 against the estate, or, if such claims have been filed, they
23 remain dormant for failure of prosecution or failure of the
24 claimant to compel administration of the estate for the
25 purpose of payment. This paragraph shall not bar recovery from
26 the estate of a spouse, under Sections 1915 and 1924 of the

1 Social Security Act and Section 5-4 of the Illinois Public Aid
2 Code, who precedes a person receiving services under this
3 Section in death. All moneys for services paid to or in behalf
4 of the person under this Section shall be claimed for recovery
5 from the deceased spouse's estate. "Homestead", as used in
6 this paragraph, means the dwelling house and contiguous real
7 estate occupied by a surviving spouse or relative, as defined
8 by the rules and regulations of the Department of Healthcare
9 and Family Services, regardless of the value of the property.

10 The Department shall increase the effectiveness of the
11 existing Community Care Program by:

12 (1) ensuring that in-home services included in the
13 care plan are available on evenings and weekends;

14 (2) ensuring that care plans contain the services that
15 eligible participants need based on the number of days in
16 a month, not limited to specific blocks of time, as
17 identified by the comprehensive assessment tool selected
18 by the Department for use statewide, not to exceed the
19 total monthly service cost maximum allowed for each
20 service; the Department shall develop administrative rules
21 to implement this item (2);

22 (3) ensuring that the participants have the right to
23 choose the services contained in their care plan and to
24 direct how those services are provided, based on
25 administrative rules established by the Department;

26 (4) ensuring that the determination of need tool is

1 accurate in determining the participants' level of need;
2 to achieve this, the Department, in conjunction with the
3 Older Adult Services Advisory Committee, shall institute a
4 study of the relationship between the Determination of
5 Need scores, level of need, service cost maximums, and the
6 development and utilization of service plans no later than
7 May 1, 2008; findings and recommendations shall be
8 presented to the Governor and the General Assembly no
9 later than January 1, 2009; recommendations shall include
10 all needed changes to the service cost maximums schedule
11 and additional covered services;

12 (5) ensuring that homemakers can provide personal care
13 services that may or may not involve contact with clients,
14 including but not limited to:

- 15 (A) bathing;
16 (B) grooming;
17 (C) toileting;
18 (D) nail care;
19 (E) transferring;
20 (F) respiratory services;
21 (G) exercise; or
22 (H) positioning;

23 (6) ensuring that homemaker program vendors are not
24 restricted from hiring homemakers who are family members
25 of clients or recommended by clients; the Department may
26 not, by rule or policy, require homemakers who are family

1 members of clients or recommended by clients to accept
2 assignments in homes other than the client;

3 (7) ensuring that the State may access maximum federal
4 matching funds by seeking approval for the Centers for
5 Medicare and Medicaid Services for modifications to the
6 State's home and community based services waiver and
7 additional waiver opportunities, including applying for
8 enrollment in the Balance Incentive Payment Program by May
9 1, 2013, in order to maximize federal matching funds; this
10 shall include, but not be limited to, modification that
11 reflects all changes in the Community Care Program
12 services and all increases in the services cost maximum;

13 (8) ensuring that the determination of need tool
14 accurately reflects the service needs of individuals with
15 Alzheimer's disease and related dementia disorders;

16 (9) ensuring that services are authorized accurately
17 and consistently for the Community Care Program (CCP); the
18 Department shall implement a Service Authorization policy
19 directive; the purpose shall be to ensure that eligibility
20 and services are authorized accurately and consistently in
21 the CCP program; the policy directive shall clarify
22 service authorization guidelines to Care Coordination
23 Units and Community Care Program providers no later than
24 May 1, 2013;

25 (10) working in conjunction with Care Coordination
26 Units, the Department of Healthcare and Family Services,

1 the Department of Human Services, Community Care Program
2 providers, and other stakeholders to make improvements to
3 the Medicaid claiming processes and the Medicaid
4 enrollment procedures or requirements as needed,
5 including, but not limited to, specific policy changes or
6 rules to improve the up-front enrollment of participants
7 in the Medicaid program and specific policy changes or
8 rules to insure more prompt submission of bills to the
9 federal government to secure maximum federal matching
10 dollars as promptly as possible; the Department on Aging
11 shall have at least 3 meetings with stakeholders by
12 January 1, 2014 in order to address these improvements;

13 (11) requiring home care service providers to comply
14 with the rounding of hours worked provisions under the
15 federal Fair Labor Standards Act (FLSA) and as set forth
16 in 29 CFR 785.48(b) by May 1, 2013;

17 (12) implementing any necessary policy changes or
18 promulgating any rules, no later than January 1, 2014, to
19 assist the Department of Healthcare and Family Services in
20 moving as many participants as possible, consistent with
21 federal regulations, into coordinated care plans if a care
22 coordination plan that covers long term care is available
23 in the recipient's area; and

24 (13) maintaining fiscal year 2014 rates at the same
25 level established on January 1, 2013.

26 By January 1, 2009 or as soon after the end of the Cash and

1 Counseling Demonstration Project as is practicable, the
2 Department may, based on its evaluation of the demonstration
3 project, promulgate rules concerning personal assistant
4 services, to include, but need not be limited to,
5 qualifications, employment screening, rights under fair labor
6 standards, training, fiduciary agent, and supervision
7 requirements. All applicants shall be subject to the
8 provisions of the Health Care Worker Background Check Act.

9 The Department shall develop procedures to enhance
10 availability of services on evenings, weekends, and on an
11 emergency basis to meet the respite needs of caregivers.
12 Procedures shall be developed to permit the utilization of
13 services in successive blocks of 24 hours up to the monthly
14 maximum established by the Department. Workers providing these
15 services shall be appropriately trained.

16 Beginning on the effective date of this amendatory Act of
17 1991, no person may perform chore/housekeeping and home care
18 aide services under a program authorized by this Section
19 unless that person has been issued a certificate of
20 pre-service to do so by his or her employing agency.
21 Information gathered to effect such certification shall
22 include (i) the person's name, (ii) the date the person was
23 hired by his or her current employer, and (iii) the training,
24 including dates and levels. Persons engaged in the program
25 authorized by this Section before the effective date of this
26 amendatory Act of 1991 shall be issued a certificate of all

1 pre- and in-service training from his or her employer upon
2 submitting the necessary information. The employing agency
3 shall be required to retain records of all staff pre- and
4 in-service training, and shall provide such records to the
5 Department upon request and upon termination of the employer's
6 contract with the Department. In addition, the employing
7 agency is responsible for the issuance of certifications of
8 in-service training completed to their employees.

9 The Department is required to develop a system to ensure
10 that persons working as home care aides and personal
11 assistants receive increases in their wages when the federal
12 minimum wage is increased by requiring vendors to certify that
13 they are meeting the federal minimum wage statute for home
14 care aides and personal assistants. An employer that cannot
15 ensure that the minimum wage increase is being given to home
16 care aides and personal assistants shall be denied any
17 increase in reimbursement costs.

18 The Community Care Program Advisory Committee is created
19 in the Department on Aging. The Director shall appoint
20 individuals to serve in the Committee, who shall serve at
21 their own expense. Members of the Committee must abide by all
22 applicable ethics laws. The Committee shall advise the
23 Department on issues related to the Department's program of
24 services to prevent unnecessary institutionalization. The
25 Committee shall meet on a bi-monthly basis and shall serve to
26 identify and advise the Department on present and potential

1 issues affecting the service delivery network, the program's
2 clients, and the Department and to recommend solution
3 strategies. Persons appointed to the Committee shall be
4 appointed on, but not limited to, their own and their agency's
5 experience with the program, geographic representation, and
6 willingness to serve. The Director shall appoint members to
7 the Committee to represent provider, advocacy, policy
8 research, and other constituencies committed to the delivery
9 of high quality home and community-based services to older
10 adults. Representatives shall be appointed to ensure
11 representation from community care providers including, but
12 not limited to, adult day service providers, homemaker
13 providers, case coordination and case management units,
14 emergency home response providers, statewide trade or labor
15 unions that represent home care aides and direct care staff,
16 area agencies on aging, adults over age 60, membership
17 organizations representing older adults, and other
18 organizational entities, providers of care, or individuals
19 with demonstrated interest and expertise in the field of home
20 and community care as determined by the Director.

21 Nominations may be presented from any agency or State
22 association with interest in the program. The Director, or his
23 or her designee, shall serve as the permanent co-chair of the
24 advisory committee. One other co-chair shall be nominated and
25 approved by the members of the committee on an annual basis.
26 Committee members' terms of appointment shall be for 4 years

1 with one-quarter of the appointees' terms expiring each year.
2 A member shall continue to serve until his or her replacement
3 is named. The Department shall fill vacancies that have a
4 remaining term of over one year, and this replacement shall
5 occur through the annual replacement of expiring terms. The
6 Director shall designate Department staff to provide technical
7 assistance and staff support to the committee. Department
8 representation shall not constitute membership of the
9 committee. All Committee papers, issues, recommendations,
10 reports, and meeting memoranda are advisory only. The
11 Director, or his or her designee, shall make a written report,
12 as requested by the Committee, regarding issues before the
13 Committee.

14 The Department on Aging and the Department of Human
15 Services shall cooperate in the development and submission of
16 an annual report on programs and services provided under this
17 Section. Such joint report shall be filed with the Governor
18 and the General Assembly on or before March 31 of the following
19 fiscal year ~~September 30 each year.~~

20 The requirement for reporting to the General Assembly
21 shall be satisfied by filing copies of the report as required
22 by Section 3.1 of the General Assembly Organization Act and
23 filing such additional copies with the State Government Report
24 Distribution Center for the General Assembly as is required
25 under paragraph (t) of Section 7 of the State Library Act.

26 Those persons previously found eligible for receiving

1 non-institutional services whose services were discontinued
2 under the Emergency Budget Act of Fiscal Year 1992, and who do
3 not meet the eligibility standards in effect on or after July
4 1, 1992, shall remain ineligible on and after July 1, 1992.
5 Those persons previously not required to cost-share and who
6 were required to cost-share effective March 1, 1992, shall
7 continue to meet cost-share requirements on and after July 1,
8 1992. Beginning July 1, 1992, all clients will be required to
9 meet eligibility, cost-share, and other requirements and will
10 have services discontinued or altered when they fail to meet
11 these requirements.

12 For the purposes of this Section, "flexible senior
13 services" refers to services that require one-time or periodic
14 expenditures including, but not limited to, respite care, home
15 modification, assistive technology, housing assistance, and
16 transportation.

17 The Department shall implement an electronic service
18 verification based on global positioning systems or other
19 cost-effective technology for the Community Care Program no
20 later than January 1, 2014.

21 The Department shall require, as a condition of
22 eligibility, enrollment in the medical assistance program
23 under Article V of the Illinois Public Aid Code (i) beginning
24 August 1, 2013, if the Auditor General has reported that the
25 Department has failed to comply with the reporting
26 requirements of Section 2-27 of the Illinois State Auditing

1 Act; or (ii) beginning June 1, 2014, if the Auditor General has
2 reported that the Department has not undertaken the required
3 actions listed in the report required by subsection (a) of
4 Section 2-27 of the Illinois State Auditing Act.

5 The Department shall delay Community Care Program services
6 until an applicant is determined eligible for medical
7 assistance under Article V of the Illinois Public Aid Code (i)
8 beginning August 1, 2013, if the Auditor General has reported
9 that the Department has failed to comply with the reporting
10 requirements of Section 2-27 of the Illinois State Auditing
11 Act; or (ii) beginning June 1, 2014, if the Auditor General has
12 reported that the Department has not undertaken the required
13 actions listed in the report required by subsection (a) of
14 Section 2-27 of the Illinois State Auditing Act.

15 The Department shall implement co-payments for the
16 Community Care Program at the federally allowable maximum
17 level (i) beginning August 1, 2013, if the Auditor General has
18 reported that the Department has failed to comply with the
19 reporting requirements of Section 2-27 of the Illinois State
20 Auditing Act; or (ii) beginning June 1, 2014, if the Auditor
21 General has reported that the Department has not undertaken
22 the required actions listed in the report required by
23 subsection (a) of Section 2-27 of the Illinois State Auditing
24 Act.

25 The Department shall continue to provide other Community
26 Care Program reports as required by statute.

1 The Department shall conduct a quarterly review of Care
2 Coordination Unit performance and adherence to service
3 guidelines. The quarterly review shall be reported to the
4 Speaker of the House of Representatives, the Minority Leader
5 of the House of Representatives, the President of the Senate,
6 and the Minority Leader of the Senate. The Department shall
7 collect and report longitudinal data on the performance of
8 each care coordination unit. Nothing in this paragraph shall
9 be construed to require the Department to identify specific
10 care coordination units.

11 In regard to community care providers, failure to comply
12 with Department on Aging policies shall be cause for
13 disciplinary action, including, but not limited to,
14 disqualification from serving Community Care Program clients.
15 Each provider, upon submission of any bill or invoice to the
16 Department for payment for services rendered, shall include a
17 notarized statement, under penalty of perjury pursuant to
18 Section 1-109 of the Code of Civil Procedure, that the
19 provider has complied with all Department policies.

20 The Director of the Department on Aging shall make
21 information available to the State Board of Elections as may
22 be required by an agreement the State Board of Elections has
23 entered into with a multi-state voter registration list
24 maintenance system.

25 Within 30 days after July 6, 2017 (the effective date of
26 Public Act 100-23), rates shall be increased to \$18.29 per

1 hour, for the purpose of increasing, by at least \$.72 per hour,
2 the wages paid by those vendors to their employees who provide
3 homemaker services. The Department shall pay an enhanced rate
4 under the Community Care Program to those in-home service
5 provider agencies that offer health insurance coverage as a
6 benefit to their direct service worker employees consistent
7 with the mandates of Public Act 95-713. For State fiscal years
8 2018 and 2019, the enhanced rate shall be \$1.77 per hour. The
9 rate shall be adjusted using actuarial analysis based on the
10 cost of care, but shall not be set below \$1.77 per hour. The
11 Department shall adopt rules, including emergency rules under
12 subsections (y) and (bb) of Section 5-45 of the Illinois
13 Administrative Procedure Act, to implement the provisions of
14 this paragraph.

15 The General Assembly finds it necessary to authorize an
16 aggressive Medicaid enrollment initiative designed to maximize
17 federal Medicaid funding for the Community Care Program which
18 produces significant savings for the State of Illinois. The
19 Department on Aging shall establish and implement a Community
20 Care Program Medicaid Initiative. Under the Initiative, the
21 Department on Aging shall, at a minimum: (i) provide an
22 enhanced rate to adequately compensate care coordination units
23 to enroll eligible Community Care Program clients into
24 Medicaid; (ii) use recommendations from a stakeholder
25 committee on how best to implement the Initiative; and (iii)
26 establish requirements for State agencies to make enrollment

1 in the State's Medical Assistance program easier for seniors.

2 The Community Care Program Medicaid Enrollment Oversight
3 Subcommittee is created as a subcommittee of the Older Adult
4 Services Advisory Committee established in Section 35 of the
5 Older Adult Services Act to make recommendations on how best
6 to increase the number of medical assistance recipients who
7 are enrolled in the Community Care Program. The Subcommittee
8 shall consist of all of the following persons who must be
9 appointed within 30 days after the effective date of this
10 amendatory Act of the 100th General Assembly:

11 (1) The Director of Aging, or his or her designee, who
12 shall serve as the chairperson of the Subcommittee.

13 (2) One representative of the Department of Healthcare
14 and Family Services, appointed by the Director of
15 Healthcare and Family Services.

16 (3) One representative of the Department of Human
17 Services, appointed by the Secretary of Human Services.

18 (4) One individual representing a care coordination
19 unit, appointed by the Director of Aging.

20 (5) One individual from a non-governmental statewide
21 organization that advocates for seniors, appointed by the
22 Director of Aging.

23 (6) One individual representing Area Agencies on
24 Aging, appointed by the Director of Aging.

25 (7) One individual from a statewide association
26 dedicated to Alzheimer's care, support, and research,

1 appointed by the Director of Aging.

2 (8) One individual from an organization that employs
3 persons who provide services under the Community Care
4 Program, appointed by the Director of Aging.

5 (9) One member of a trade or labor union representing
6 persons who provide services under the Community Care
7 Program, appointed by the Director of Aging.

8 (10) One member of the Senate, who shall serve as
9 co-chairperson, appointed by the President of the Senate.

10 (11) One member of the Senate, who shall serve as
11 co-chairperson, appointed by the Minority Leader of the
12 Senate.

13 (12) One member of the House of Representatives, who
14 shall serve as co-chairperson, appointed by the Speaker of
15 the House of Representatives.

16 (13) One member of the House of Representatives, who
17 shall serve as co-chairperson, appointed by the Minority
18 Leader of the House of Representatives.

19 (14) One individual appointed by a labor organization
20 representing frontline employees at the Department of
21 Human Services.

22 The Subcommittee shall provide oversight to the Community
23 Care Program Medicaid Initiative and shall meet quarterly. At
24 each Subcommittee meeting the Department on Aging shall
25 provide the following data sets to the Subcommittee: (A) the
26 number of Illinois residents, categorized by planning and

1 service area, who are receiving services under the Community
2 Care Program and are enrolled in the State's Medical
3 Assistance Program; (B) the number of Illinois residents,
4 categorized by planning and service area, who are receiving
5 services under the Community Care Program, but are not
6 enrolled in the State's Medical Assistance Program; and (C)
7 the number of Illinois residents, categorized by planning and
8 service area, who are receiving services under the Community
9 Care Program and are eligible for benefits under the State's
10 Medical Assistance Program, but are not enrolled in the
11 State's Medical Assistance Program. In addition to this data,
12 the Department on Aging shall provide the Subcommittee with
13 plans on how the Department on Aging will reduce the number of
14 Illinois residents who are not enrolled in the State's Medical
15 Assistance Program but who are eligible for medical assistance
16 benefits. The Department on Aging shall enroll in the State's
17 Medical Assistance Program those Illinois residents who
18 receive services under the Community Care Program and are
19 eligible for medical assistance benefits but are not enrolled
20 in the State's Medicaid Assistance Program. The data provided
21 to the Subcommittee shall be made available to the public via
22 the Department on Aging's website.

23 The Department on Aging, with the involvement of the
24 Subcommittee, shall collaborate with the Department of Human
25 Services and the Department of Healthcare and Family Services
26 on how best to achieve the responsibilities of the Community

1 Care Program Medicaid Initiative.

2 The Department on Aging, the Department of Human Services,
3 and the Department of Healthcare and Family Services shall
4 coordinate and implement a streamlined process for seniors to
5 access benefits under the State's Medical Assistance Program.

6 The Subcommittee shall collaborate with the Department of
7 Human Services on the adoption of a uniform application
8 submission process. The Department of Human Services and any
9 other State agency involved with processing the medical
10 assistance application of any person enrolled in the Community
11 Care Program shall include the appropriate care coordination
12 unit in all communications related to the determination or
13 status of the application.

14 The Community Care Program Medicaid Initiative shall
15 provide targeted funding to care coordination units to help
16 seniors complete their applications for medical assistance
17 benefits. On and after July 1, 2019, care coordination units
18 shall receive no less than \$200 per completed application,
19 which rate may be included in a bundled rate for initial intake
20 services when Medicaid application assistance is provided in
21 conjunction with the initial intake process for new program
22 participants.

23 The Community Care Program Medicaid Initiative shall cease
24 operation 5 years after the effective date of this amendatory
25 Act of the 100th General Assembly, after which the
26 Subcommittee shall dissolve.

1 (Source: P.A. 101-10, eff. 6-5-19; 102-1071, eff. 6-10-22.)

2 (20 ILCS 105/4.07)

3 Sec. 4.07. Home-delivered meals.

4 (a) Every citizen of the State of Illinois who qualifies
5 for home-delivered meals under the federal Older Americans Act
6 shall be provided services, subject to appropriation. The
7 Department shall file a report with the General Assembly and
8 the Illinois Council on Aging by March 31 of the following
9 fiscal year ~~January 1 of each year~~. The report shall include,
10 but not be limited to, the following information: (i)
11 estimates, by county, of citizens denied service due to
12 insufficient funds during the preceding fiscal year and the
13 potential impact on service delivery of any additional funds
14 appropriated for the current fiscal year; (ii) geographic
15 areas and special populations unserved and underserved in the
16 preceding fiscal year; (iii) estimates of additional funds
17 needed to permit the full funding of the program and the
18 statewide provision of services in the next fiscal year,
19 including staffing and equipment needed to prepare and deliver
20 meals; (iv) recommendations for increasing the amount of
21 federal funding captured for the program; (v) recommendations
22 for serving unserved and underserved areas and special
23 populations, to include rural areas, dietetic meals, weekend
24 meals, and 2 or more meals per day; and (vi) any other
25 information needed to assist the General Assembly and the

1 Illinois Council on Aging in developing a plan to address
2 unserved and underserved areas of the State.

3 (b) Subject to appropriation, on an annual basis each
4 recipient of home-delivered meals shall receive a fact sheet
5 developed by the Department on Aging with a current list of
6 toll-free numbers to access information on various health
7 conditions, elder abuse, and programs for persons 60 years of
8 age and older. The fact sheet shall be written in a language
9 that the client understands, if possible. In addition, each
10 recipient of home-delivered meals shall receive updates on any
11 new program for which persons 60 years of age and older may be
12 eligible.

13 (Source: P.A. 102-253, eff. 8-6-21.)

14 Section 90-10. The Respite Program Act is amended by
15 changing Section 12 as follows:

16 (320 ILCS 10/12) (from Ch. 23, par. 6212)

17 Sec. 12. Annual report. The Director shall submit a report
18 by March 31 of the following fiscal year ~~each year~~ to the
19 Governor and the General Assembly detailing the progress of
20 the respite care services provided under this Act and shall
21 also include an estimate of the demand for respite care
22 services over the next 10 years.

23 (Source: P.A. 100-972, eff. 1-1-19.)

1 ARTICLE 95.

2 Section 95-5. The Hospital Licensing Act is amended by
3 changing Section 6.09 as follows:

4 (210 ILCS 85/6.09) (from Ch. 111 1/2, par. 147.09)

5 Sec. 6.09. (a) In order to facilitate the orderly
6 transition of aged patients and patients with disabilities
7 from hospitals to post-hospital care, whenever a patient who
8 qualifies for the federal Medicare program is hospitalized,
9 the patient shall be notified of discharge at least 24 hours
10 prior to discharge from the hospital. With regard to pending
11 discharges to a skilled nursing facility, the hospital must
12 notify the case coordination unit, as defined in 89 Ill. Adm.
13 Code 240.260, at least 24 hours prior to discharge. When the
14 assessment is completed in the hospital, the case coordination
15 unit shall provide a copy of the required assessment
16 documentation directly to the nursing home to which the
17 patient is being discharged prior to discharge. The Department
18 on Aging shall provide notice of this requirement to case
19 coordination units. When a case coordination unit is unable to
20 complete an assessment in a hospital prior to the discharge of
21 a patient, 60 years of age or older, to a nursing home, the
22 case coordination unit shall notify the Department on Aging
23 which shall notify the Department of Healthcare and Family
24 Services. The ~~Department of Healthcare and Family Services and~~

1 ~~the~~ Department on Aging shall adopt rules to address these
2 instances to ensure that the patient is able to access nursing
3 home care, the nursing home is not penalized for accepting the
4 admission, and the patient's timely discharge from the
5 hospital is not delayed, to the extent permitted under federal
6 law or regulation. Nothing in this subsection shall preclude
7 federal requirements for a pre-admission screening/mental
8 health (PAS/MH) as required under Section 2-201.5 of the
9 Nursing Home Care Act or State or federal law or regulation. If
10 home health services are ordered, the hospital must inform its
11 designated case coordination unit, as defined in 89 Ill. Adm.
12 Code 240.260, of the pending discharge and must provide the
13 patient with the case coordination unit's telephone number and
14 other contact information.

15 (b) Every hospital shall develop procedures for a
16 physician with medical staff privileges at the hospital or any
17 appropriate medical staff member to provide the discharge
18 notice prescribed in subsection (a) of this Section. The
19 procedures must include prohibitions against discharging or
20 referring a patient to any of the following if unlicensed,
21 uncertified, or unregistered: (i) a board and care facility,
22 as defined in the Board and Care Home Act; (ii) an assisted
23 living and shared housing establishment, as defined in the
24 Assisted Living and Shared Housing Act; (iii) a facility
25 licensed under the Nursing Home Care Act, the Specialized
26 Mental Health Rehabilitation Act of 2013, the ID/DD Community

1 Care Act, or the MC/DD Act; (iv) a supportive living facility,
2 as defined in Section 5-5.01a of the Illinois Public Aid Code;
3 or (v) a free-standing hospice facility licensed under the
4 Hospice Program Licensing Act if licensure, certification, or
5 registration is required. The Department of Public Health
6 shall annually provide hospitals with a list of licensed,
7 certified, or registered board and care facilities, assisted
8 living and shared housing establishments, nursing homes,
9 supportive living facilities, facilities licensed under the
10 ID/DD Community Care Act, the MC/DD Act, or the Specialized
11 Mental Health Rehabilitation Act of 2013, and hospice
12 facilities. Reliance upon this list by a hospital shall
13 satisfy compliance with this requirement. The procedure may
14 also include a waiver for any case in which a discharge notice
15 is not feasible due to a short length of stay in the hospital
16 by the patient, or for any case in which the patient
17 voluntarily desires to leave the hospital before the
18 expiration of the 24 hour period.

19 (c) At least 24 hours prior to discharge from the
20 hospital, the patient shall receive written information on the
21 patient's right to appeal the discharge pursuant to the
22 federal Medicare program, including the steps to follow to
23 appeal the discharge and the appropriate telephone number to
24 call in case the patient intends to appeal the discharge.

25 (d) Before transfer of a patient to a long term care
26 facility licensed under the Nursing Home Care Act where

1 elderly persons reside, a hospital shall as soon as
2 practicable initiate a name-based criminal history background
3 check by electronic submission to the Illinois State Police
4 for all persons between the ages of 18 and 70 years; provided,
5 however, that a hospital shall be required to initiate such a
6 background check only with respect to patients who:

7 (1) are transferring to a long term care facility for
8 the first time;

9 (2) have been in the hospital more than 5 days;

10 (3) are reasonably expected to remain at the long term
11 care facility for more than 30 days;

12 (4) have a known history of serious mental illness or
13 substance abuse; and

14 (5) are independently ambulatory or mobile for more
15 than a temporary period of time.

16 A hospital may also request a criminal history background
17 check for a patient who does not meet any of the criteria set
18 forth in items (1) through (5).

19 A hospital shall notify a long term care facility if the
20 hospital has initiated a criminal history background check on
21 a patient being discharged to that facility. In all
22 circumstances in which the hospital is required by this
23 subsection to initiate the criminal history background check,
24 the transfer to the long term care facility may proceed
25 regardless of the availability of criminal history results.
26 Upon receipt of the results, the hospital shall promptly

1 forward the results to the appropriate long term care
2 facility. If the results of the background check are
3 inconclusive, the hospital shall have no additional duty or
4 obligation to seek additional information from, or about, the
5 patient.

6 (Source: P.A. 102-538, eff. 8-20-21.)

7 Section 95-10. The Illinois Insurance Code is amended by
8 changing Section 5.5 as follows:

9 (215 ILCS 5/5.5)

10 Sec. 5.5. Compliance with the Department of Healthcare and
11 Family Services. A company authorized to do business in this
12 State or accredited by the State to issue policies of health
13 insurance, including but not limited to, self-insured plans,
14 group health plans (as defined in Section 607(1) of the
15 Employee Retirement Income Security Act of 1974), service
16 benefit plans, managed care organizations, pharmacy benefit
17 managers, or other parties that are by statute, contract, or
18 agreement legally responsible for payment of a claim for a
19 health care item or service as a condition of doing business in
20 the State must:

21 (1) provide to the Department of Healthcare and Family
22 Services, or any successor agency, on at least a quarterly
23 basis if so requested by the Department, information to
24 determine during what period any individual may be, or may

1 have been, covered by a health insurer and the nature of
2 the coverage that is or was provided by the health
3 insurer, including the name, address, and identifying
4 number of the plan;

5 (2) accept the State's right of recovery and the
6 assignment to the State of any right of an individual or
7 other entity to payment from the party for an item or
8 service for which payment has been made under the medical
9 programs of the Department of Healthcare and Family
10 Services, or any successor or authorized agency, under
11 this Code, ~~or~~ the Illinois Public Aid Code, or any other
12 applicable law; and (other than parties expressly excluded
13 under 42 U.S.C. 1396a(a)(25)(I)(ii)(II)) accept
14 authorization provided by the State that the item or
15 service is covered under such medical programs for the
16 individual, as if the State's authorization was the prior
17 authorization made by the company for the item or service;

18 (3) not later than 60 days after receiving ~~respond to~~
19 any inquiry by the Department of Healthcare and Family
20 Services regarding a claim for payment for any health care
21 item or service that is submitted not later than 3 years
22 after the date of the provision of such health care item or
23 service, respond to such inquiry; and

24 (4) agree not to deny a claim submitted by the
25 Department of Healthcare and Family Services solely on the
26 basis of the date of submission of the claim, the type or

1 format of the claim form, ~~or~~ a failure to present proper
2 documentation at the point-of-sale that is the basis of
3 the claim, or (other than parties expressly excluded under
4 42 U.S.C. 1396a(a)(25)(I)(iv)) a failure to obtain a prior
5 authorization for the item or service for which the claim
6 is being submitted if (i) the claim is submitted by the
7 Department of Healthcare and Family Services within the
8 3-year period beginning on the date on which the item or
9 service was furnished and (ii) any action by the
10 Department of Healthcare and Family Services to enforce
11 its rights with respect to such claim is commenced within
12 6 years of its submission of such claim.

13 The Department of Healthcare and Family Services may
14 impose an administrative penalty as provided under Section
15 12-4.45 of the Illinois Public Aid Code on entities that have
16 established a pattern of failure to provide the information
17 required under this Section, or in cases in which the
18 Department of Healthcare and Family Services has determined
19 that an entity that provides health insurance coverage has
20 established a pattern of failure to provide the information
21 required under this Section, and has subsequently certified
22 that determination, along with supporting documentation, to
23 the Director of the Department of Insurance, the Director of
24 the Department of Insurance, based upon the certification of
25 determination made by the Department of Healthcare and Family
26 Services, may commence regulatory proceedings in accordance

1 with all applicable provisions of the Illinois Insurance Code.
2 (Source: P.A. 98-130, eff. 8-2-13.)

3 Section 95-15. The Illinois Public Aid Code is amended by
4 changing Sections 5-5 and 12-8 as follows:

5 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

6 Sec. 5-5. Medical services. The Illinois Department, by
7 rule, shall determine the quantity and quality of and the rate
8 of reimbursement for the medical assistance for which payment
9 will be authorized, and the medical services to be provided,
10 which may include all or part of the following: (1) inpatient
11 hospital services; (2) outpatient hospital services; (3) other
12 laboratory and X-ray services; (4) skilled nursing home
13 services; (5) physicians' services whether furnished in the
14 office, the patient's home, a hospital, a skilled nursing
15 home, or elsewhere; (6) medical care, or any other type of
16 remedial care furnished by licensed practitioners; (7) home
17 health care services; (8) private duty nursing service; (9)
18 clinic services; (10) dental services, including prevention
19 and treatment of periodontal disease and dental caries disease
20 for pregnant individuals, provided by an individual licensed
21 to practice dentistry or dental surgery; for purposes of this
22 item (10), "dental services" means diagnostic, preventive, or
23 corrective procedures provided by or under the supervision of
24 a dentist in the practice of his or her profession; (11)

1 physical therapy and related services; (12) prescribed drugs,
2 dentures, and prosthetic devices; and eyeglasses prescribed by
3 a physician skilled in the diseases of the eye, or by an
4 optometrist, whichever the person may select; (13) other
5 diagnostic, screening, preventive, and rehabilitative
6 services, including to ensure that the individual's need for
7 intervention or treatment of mental disorders or substance use
8 disorders or co-occurring mental health and substance use
9 disorders is determined using a uniform screening, assessment,
10 and evaluation process inclusive of criteria, for children and
11 adults; for purposes of this item (13), a uniform screening,
12 assessment, and evaluation process refers to a process that
13 includes an appropriate evaluation and, as warranted, a
14 referral; "uniform" does not mean the use of a singular
15 instrument, tool, or process that all must utilize; (14)
16 transportation and such other expenses as may be necessary;
17 (15) medical treatment of sexual assault survivors, as defined
18 in Section 1a of the Sexual Assault Survivors Emergency
19 Treatment Act, for injuries sustained as a result of the
20 sexual assault, including examinations and laboratory tests to
21 discover evidence which may be used in criminal proceedings
22 arising from the sexual assault; (16) the diagnosis and
23 treatment of sickle cell anemia; (16.5) services performed by
24 a chiropractic physician licensed under the Medical Practice
25 Act of 1987 and acting within the scope of his or her license,
26 including, but not limited to, chiropractic manipulative

1 treatment; and (17) any other medical care, and any other type
2 of remedial care recognized under the laws of this State. The
3 term "any other type of remedial care" shall include nursing
4 care and nursing home service for persons who rely on
5 treatment by spiritual means alone through prayer for healing.

6 Notwithstanding any other provision of this Section, a
7 comprehensive tobacco use cessation program that includes
8 purchasing prescription drugs or prescription medical devices
9 approved by the Food and Drug Administration shall be covered
10 under the medical assistance program under this Article for
11 persons who are otherwise eligible for assistance under this
12 Article.

13 Notwithstanding any other provision of this Code,
14 reproductive health care that is otherwise legal in Illinois
15 shall be covered under the medical assistance program for
16 persons who are otherwise eligible for medical assistance
17 under this Article.

18 Notwithstanding any other provision of this Section, all
19 tobacco cessation medications approved by the United States
20 Food and Drug Administration and all individual and group
21 tobacco cessation counseling services and telephone-based
22 counseling services and tobacco cessation medications provided
23 through the Illinois Tobacco Quitline shall be covered under
24 the medical assistance program for persons who are otherwise
25 eligible for assistance under this Article. The Department
26 shall comply with all federal requirements necessary to obtain

1 federal financial participation, as specified in 42 CFR
2 433.15(b)(7), for telephone-based counseling services provided
3 through the Illinois Tobacco Quitline, including, but not
4 limited to: (i) entering into a memorandum of understanding or
5 interagency agreement with the Department of Public Health, as
6 administrator of the Illinois Tobacco Quitline; and (ii)
7 developing a cost allocation plan for Medicaid-allowable
8 Illinois Tobacco Quitline services in accordance with 45 CFR
9 95.507. The Department shall submit the memorandum of
10 understanding or interagency agreement, the cost allocation
11 plan, and all other necessary documentation to the Centers for
12 Medicare and Medicaid Services for review and approval.
13 Coverage under this paragraph shall be contingent upon federal
14 approval.

15 Notwithstanding any other provision of this Code, the
16 Illinois Department may not require, as a condition of payment
17 for any laboratory test authorized under this Article, that a
18 physician's handwritten signature appear on the laboratory
19 test order form. The Illinois Department may, however, impose
20 other appropriate requirements regarding laboratory test order
21 documentation.

22 Upon receipt of federal approval of an amendment to the
23 Illinois Title XIX State Plan for this purpose, the Department
24 shall authorize the Chicago Public Schools (CPS) to procure a
25 vendor or vendors to manufacture eyeglasses for individuals
26 enrolled in a school within the CPS system. CPS shall ensure

1 that its vendor or vendors are enrolled as providers in the
2 medical assistance program and in any capitated Medicaid
3 managed care entity (MCE) serving individuals enrolled in a
4 school within the CPS system. Under any contract procured
5 under this provision, the vendor or vendors must serve only
6 individuals enrolled in a school within the CPS system. Claims
7 for services provided by CPS's vendor or vendors to recipients
8 of benefits in the medical assistance program under this Code,
9 the Children's Health Insurance Program, or the Covering ALL
10 KIDS Health Insurance Program shall be submitted to the
11 Department or the MCE in which the individual is enrolled for
12 payment and shall be reimbursed at the Department's or the
13 MCE's established rates or rate methodologies for eyeglasses.

14 On and after July 1, 2012, the Department of Healthcare
15 and Family Services may provide the following services to
16 persons eligible for assistance under this Article who are
17 participating in education, training or employment programs
18 operated by the Department of Human Services as successor to
19 the Department of Public Aid:

20 (1) dental services provided by or under the
21 supervision of a dentist; and

22 (2) eyeglasses prescribed by a physician skilled in
23 the diseases of the eye, or by an optometrist, whichever
24 the person may select.

25 On and after July 1, 2018, the Department of Healthcare
26 and Family Services shall provide dental services to any adult

1 who is otherwise eligible for assistance under the medical
2 assistance program. As used in this paragraph, "dental
3 services" means diagnostic, preventative, restorative, or
4 corrective procedures, including procedures and services for
5 the prevention and treatment of periodontal disease and dental
6 caries disease, provided by an individual who is licensed to
7 practice dentistry or dental surgery or who is under the
8 supervision of a dentist in the practice of his or her
9 profession.

10 On and after July 1, 2018, targeted dental services, as
11 set forth in Exhibit D of the Consent Decree entered by the
12 United States District Court for the Northern District of
13 Illinois, Eastern Division, in the matter of Memisovski v.
14 Maram, Case No. 92 C 1982, that are provided to adults under
15 the medical assistance program shall be established at no less
16 than the rates set forth in the "New Rate" column in Exhibit D
17 of the Consent Decree for targeted dental services that are
18 provided to persons under the age of 18 under the medical
19 assistance program.

20 Notwithstanding any other provision of this Code and
21 subject to federal approval, the Department may adopt rules to
22 allow a dentist who is volunteering his or her service at no
23 cost to render dental services through an enrolled
24 not-for-profit health clinic without the dentist personally
25 enrolling as a participating provider in the medical
26 assistance program. A not-for-profit health clinic shall

1 include a public health clinic or Federally Qualified Health
2 Center or other enrolled provider, as determined by the
3 Department, through which dental services covered under this
4 Section are performed. The Department shall establish a
5 process for payment of claims for reimbursement for covered
6 dental services rendered under this provision.

7 On and after January 1, 2022, the Department of Healthcare
8 and Family Services shall administer and regulate a
9 school-based dental program that allows for the out-of-office
10 delivery of preventative dental services in a school setting
11 to children under 19 years of age. The Department shall
12 establish, by rule, guidelines for participation by providers
13 and set requirements for follow-up referral care based on the
14 requirements established in the Dental Office Reference Manual
15 published by the Department that establishes the requirements
16 for dentists participating in the All Kids Dental School
17 Program. Every effort shall be made by the Department when
18 developing the program requirements to consider the different
19 geographic differences of both urban and rural areas of the
20 State for initial treatment and necessary follow-up care. No
21 provider shall be charged a fee by any unit of local government
22 to participate in the school-based dental program administered
23 by the Department. Nothing in this paragraph shall be
24 construed to limit or preempt a home rule unit's or school
25 district's authority to establish, change, or administer a
26 school-based dental program in addition to, or independent of,

1 the school-based dental program administered by the
2 Department.

3 The Illinois Department, by rule, may distinguish and
4 classify the medical services to be provided only in
5 accordance with the classes of persons designated in Section
6 5-2.

7 The Department of Healthcare and Family Services must
8 provide coverage and reimbursement for amino acid-based
9 elemental formulas, regardless of delivery method, for the
10 diagnosis and treatment of (i) eosinophilic disorders and (ii)
11 short bowel syndrome when the prescribing physician has issued
12 a written order stating that the amino acid-based elemental
13 formula is medically necessary.

14 The Illinois Department shall authorize the provision of,
15 and shall authorize payment for, screening by low-dose
16 mammography for the presence of occult breast cancer for
17 individuals 35 years of age or older who are eligible for
18 medical assistance under this Article, as follows:

19 (A) A baseline mammogram for individuals 35 to 39
20 years of age.

21 (B) An annual mammogram for individuals 40 years of
22 age or older.

23 (C) A mammogram at the age and intervals considered
24 medically necessary by the individual's health care
25 provider for individuals under 40 years of age and having
26 a family history of breast cancer, prior personal history

1 of breast cancer, positive genetic testing, or other risk
2 factors.

3 (D) A comprehensive ultrasound screening and MRI of an
4 entire breast or breasts if a mammogram demonstrates
5 heterogeneous or dense breast tissue or when medically
6 necessary as determined by a physician licensed to
7 practice medicine in all of its branches.

8 (E) A screening MRI when medically necessary, as
9 determined by a physician licensed to practice medicine in
10 all of its branches.

11 (F) A diagnostic mammogram when medically necessary,
12 as determined by a physician licensed to practice medicine
13 in all its branches, advanced practice registered nurse,
14 or physician assistant.

15 The Department shall not impose a deductible, coinsurance,
16 copayment, or any other cost-sharing requirement on the
17 coverage provided under this paragraph; except that this
18 sentence does not apply to coverage of diagnostic mammograms
19 to the extent such coverage would disqualify a high-deductible
20 health plan from eligibility for a health savings account
21 pursuant to Section 223 of the Internal Revenue Code (26
22 U.S.C. 223).

23 All screenings shall include a physical breast exam,
24 instruction on self-examination and information regarding the
25 frequency of self-examination and its value as a preventative
26 tool.

1 For purposes of this Section:

2 "Diagnostic mammogram" means a mammogram obtained using
3 diagnostic mammography.

4 "Diagnostic mammography" means a method of screening that
5 is designed to evaluate an abnormality in a breast, including
6 an abnormality seen or suspected on a screening mammogram or a
7 subjective or objective abnormality otherwise detected in the
8 breast.

9 "Low-dose mammography" means the x-ray examination of the
10 breast using equipment dedicated specifically for mammography,
11 including the x-ray tube, filter, compression device, and
12 image receptor, with an average radiation exposure delivery of
13 less than one rad per breast for 2 views of an average size
14 breast. The term also includes digital mammography and
15 includes breast tomosynthesis.

16 "Breast tomosynthesis" means a radiologic procedure that
17 involves the acquisition of projection images over the
18 stationary breast to produce cross-sectional digital
19 three-dimensional images of the breast.

20 If, at any time, the Secretary of the United States
21 Department of Health and Human Services, or its successor
22 agency, promulgates rules or regulations to be published in
23 the Federal Register or publishes a comment in the Federal
24 Register or issues an opinion, guidance, or other action that
25 would require the State, pursuant to any provision of the
26 Patient Protection and Affordable Care Act (Public Law

1 111-148), including, but not limited to, 42 U.S.C.
2 18031(d)(3)(B) or any successor provision, to defray the cost
3 of any coverage for breast tomosynthesis outlined in this
4 paragraph, then the requirement that an insurer cover breast
5 tomosynthesis is inoperative other than any such coverage
6 authorized under Section 1902 of the Social Security Act, 42
7 U.S.C. 1396a, and the State shall not assume any obligation
8 for the cost of coverage for breast tomosynthesis set forth in
9 this paragraph.

10 On and after January 1, 2016, the Department shall ensure
11 that all networks of care for adult clients of the Department
12 include access to at least one breast imaging Center of
13 Imaging Excellence as certified by the American College of
14 Radiology.

15 On and after January 1, 2012, providers participating in a
16 quality improvement program approved by the Department shall
17 be reimbursed for screening and diagnostic mammography at the
18 same rate as the Medicare program's rates, including the
19 increased reimbursement for digital mammography and, after
20 January 1, 2023 (the effective date of Public Act 102-1018)
21 ~~this amendatory Act of the 102nd General Assembly~~, breast
22 tomosynthesis.

23 The Department shall convene an expert panel including
24 representatives of hospitals, free-standing mammography
25 facilities, and doctors, including radiologists, to establish
26 quality standards for mammography.

1 On and after January 1, 2017, providers participating in a
2 breast cancer treatment quality improvement program approved
3 by the Department shall be reimbursed for breast cancer
4 treatment at a rate that is no lower than 95% of the Medicare
5 program's rates for the data elements included in the breast
6 cancer treatment quality program.

7 The Department shall convene an expert panel, including
8 representatives of hospitals, free-standing breast cancer
9 treatment centers, breast cancer quality organizations, and
10 doctors, including breast surgeons, reconstructive breast
11 surgeons, oncologists, and primary care providers to establish
12 quality standards for breast cancer treatment.

13 Subject to federal approval, the Department shall
14 establish a rate methodology for mammography at federally
15 qualified health centers and other encounter-rate clinics.
16 These clinics or centers may also collaborate with other
17 hospital-based mammography facilities. By January 1, 2016, the
18 Department shall report to the General Assembly on the status
19 of the provision set forth in this paragraph.

20 The Department shall establish a methodology to remind
21 individuals who are age-appropriate for screening mammography,
22 but who have not received a mammogram within the previous 18
23 months, of the importance and benefit of screening
24 mammography. The Department shall work with experts in breast
25 cancer outreach and patient navigation to optimize these
26 reminders and shall establish a methodology for evaluating

1 their effectiveness and modifying the methodology based on the
2 evaluation.

3 The Department shall establish a performance goal for
4 primary care providers with respect to their female patients
5 over age 40 receiving an annual mammogram. This performance
6 goal shall be used to provide additional reimbursement in the
7 form of a quality performance bonus to primary care providers
8 who meet that goal.

9 The Department shall devise a means of case-managing or
10 patient navigation for beneficiaries diagnosed with breast
11 cancer. This program shall initially operate as a pilot
12 program in areas of the State with the highest incidence of
13 mortality related to breast cancer. At least one pilot program
14 site shall be in the metropolitan Chicago area and at least one
15 site shall be outside the metropolitan Chicago area. On or
16 after July 1, 2016, the pilot program shall be expanded to
17 include one site in western Illinois, one site in southern
18 Illinois, one site in central Illinois, and 4 sites within
19 metropolitan Chicago. An evaluation of the pilot program shall
20 be carried out measuring health outcomes and cost of care for
21 those served by the pilot program compared to similarly
22 situated patients who are not served by the pilot program.

23 The Department shall require all networks of care to
24 develop a means either internally or by contract with experts
25 in navigation and community outreach to navigate cancer
26 patients to comprehensive care in a timely fashion. The

1 Department shall require all networks of care to include
2 access for patients diagnosed with cancer to at least one
3 academic commission on cancer-accredited cancer program as an
4 in-network covered benefit.

5 The Department shall provide coverage and reimbursement
6 for a human papillomavirus (HPV) vaccine that is approved for
7 marketing by the federal Food and Drug Administration for all
8 persons between the ages of 9 and 45. Subject to federal
9 approval, the Department shall provide coverage and
10 reimbursement for a human papillomavirus (HPV) vaccine for ~~and~~
11 persons of the age of 46 and above who have been diagnosed with
12 cervical dysplasia with a high risk of recurrence or
13 progression. The Department shall disallow any
14 preauthorization requirements for the administration of the
15 human papillomavirus (HPV) vaccine.

16 On or after July 1, 2022, individuals who are otherwise
17 eligible for medical assistance under this Article shall
18 receive coverage for perinatal depression screenings for the
19 12-month period beginning on the last day of their pregnancy.
20 Medical assistance coverage under this paragraph shall be
21 conditioned on the use of a screening instrument approved by
22 the Department.

23 Any medical or health care provider shall immediately
24 recommend, to any pregnant individual who is being provided
25 prenatal services and is suspected of having a substance use
26 disorder as defined in the Substance Use Disorder Act,

1 referral to a local substance use disorder treatment program
2 licensed by the Department of Human Services or to a licensed
3 hospital which provides substance abuse treatment services.
4 The Department of Healthcare and Family Services shall assure
5 coverage for the cost of treatment of the drug abuse or
6 addiction for pregnant recipients in accordance with the
7 Illinois Medicaid Program in conjunction with the Department
8 of Human Services.

9 All medical providers providing medical assistance to
10 pregnant individuals under this Code shall receive information
11 from the Department on the availability of services under any
12 program providing case management services for addicted
13 individuals, including information on appropriate referrals
14 for other social services that may be needed by addicted
15 individuals in addition to treatment for addiction.

16 The Illinois Department, in cooperation with the
17 Departments of Human Services (as successor to the Department
18 of Alcoholism and Substance Abuse) and Public Health, through
19 a public awareness campaign, may provide information
20 concerning treatment for alcoholism and drug abuse and
21 addiction, prenatal health care, and other pertinent programs
22 directed at reducing the number of drug-affected infants born
23 to recipients of medical assistance.

24 Neither the Department of Healthcare and Family Services
25 nor the Department of Human Services shall sanction the
26 recipient solely on the basis of the recipient's substance

1 abuse.

2 The Illinois Department shall establish such regulations
3 governing the dispensing of health services under this Article
4 as it shall deem appropriate. The Department should seek the
5 advice of formal professional advisory committees appointed by
6 the Director of the Illinois Department for the purpose of
7 providing regular advice on policy and administrative matters,
8 information dissemination and educational activities for
9 medical and health care providers, and consistency in
10 procedures to the Illinois Department.

11 The Illinois Department may develop and contract with
12 Partnerships of medical providers to arrange medical services
13 for persons eligible under Section 5-2 of this Code.
14 Implementation of this Section may be by demonstration
15 projects in certain geographic areas. The Partnership shall be
16 represented by a sponsor organization. The Department, by
17 rule, shall develop qualifications for sponsors of
18 Partnerships. Nothing in this Section shall be construed to
19 require that the sponsor organization be a medical
20 organization.

21 The sponsor must negotiate formal written contracts with
22 medical providers for physician services, inpatient and
23 outpatient hospital care, home health services, treatment for
24 alcoholism and substance abuse, and other services determined
25 necessary by the Illinois Department by rule for delivery by
26 Partnerships. Physician services must include prenatal and

1 obstetrical care. The Illinois Department shall reimburse
2 medical services delivered by Partnership providers to clients
3 in target areas according to provisions of this Article and
4 the Illinois Health Finance Reform Act, except that:

5 (1) Physicians participating in a Partnership and
6 providing certain services, which shall be determined by
7 the Illinois Department, to persons in areas covered by
8 the Partnership may receive an additional surcharge for
9 such services.

10 (2) The Department may elect to consider and negotiate
11 financial incentives to encourage the development of
12 Partnerships and the efficient delivery of medical care.

13 (3) Persons receiving medical services through
14 Partnerships may receive medical and case management
15 services above the level usually offered through the
16 medical assistance program.

17 Medical providers shall be required to meet certain
18 qualifications to participate in Partnerships to ensure the
19 delivery of high quality medical services. These
20 qualifications shall be determined by rule of the Illinois
21 Department and may be higher than qualifications for
22 participation in the medical assistance program. Partnership
23 sponsors may prescribe reasonable additional qualifications
24 for participation by medical providers, only with the prior
25 written approval of the Illinois Department.

26 Nothing in this Section shall limit the free choice of

1 practitioners, hospitals, and other providers of medical
2 services by clients. In order to ensure patient freedom of
3 choice, the Illinois Department shall immediately promulgate
4 all rules and take all other necessary actions so that
5 provided services may be accessed from therapeutically
6 certified optometrists to the full extent of the Illinois
7 Optometric Practice Act of 1987 without discriminating between
8 service providers.

9 The Department shall apply for a waiver from the United
10 States Health Care Financing Administration to allow for the
11 implementation of Partnerships under this Section.

12 The Illinois Department shall require health care
13 providers to maintain records that document the medical care
14 and services provided to recipients of Medical Assistance
15 under this Article. Such records must be retained for a period
16 of not less than 6 years from the date of service or as
17 provided by applicable State law, whichever period is longer,
18 except that if an audit is initiated within the required
19 retention period then the records must be retained until the
20 audit is completed and every exception is resolved. The
21 Illinois Department shall require health care providers to
22 make available, when authorized by the patient, in writing,
23 the medical records in a timely fashion to other health care
24 providers who are treating or serving persons eligible for
25 Medical Assistance under this Article. All dispensers of
26 medical services shall be required to maintain and retain

1 business and professional records sufficient to fully and
2 accurately document the nature, scope, details and receipt of
3 the health care provided to persons eligible for medical
4 assistance under this Code, in accordance with regulations
5 promulgated by the Illinois Department. The rules and
6 regulations shall require that proof of the receipt of
7 prescription drugs, dentures, prosthetic devices and
8 eyeglasses by eligible persons under this Section accompany
9 each claim for reimbursement submitted by the dispenser of
10 such medical services. No such claims for reimbursement shall
11 be approved for payment by the Illinois Department without
12 such proof of receipt, unless the Illinois Department shall
13 have put into effect and shall be operating a system of
14 post-payment audit and review which shall, on a sampling
15 basis, be deemed adequate by the Illinois Department to assure
16 that such drugs, dentures, prosthetic devices and eyeglasses
17 for which payment is being made are actually being received by
18 eligible recipients. Within 90 days after September 16, 1984
19 (the effective date of Public Act 83-1439), the Illinois
20 Department shall establish a current list of acquisition costs
21 for all prosthetic devices and any other items recognized as
22 medical equipment and supplies reimbursable under this Article
23 and shall update such list on a quarterly basis, except that
24 the acquisition costs of all prescription drugs shall be
25 updated no less frequently than every 30 days as required by
26 Section 5-5.12.

1 Notwithstanding any other law to the contrary, the
2 Illinois Department shall, within 365 days after July 22, 2013
3 (the effective date of Public Act 98-104), establish
4 procedures to permit skilled care facilities licensed under
5 the Nursing Home Care Act to submit monthly billing claims for
6 reimbursement purposes. Following development of these
7 procedures, the Department shall, by July 1, 2016, test the
8 viability of the new system and implement any necessary
9 operational or structural changes to its information
10 technology platforms in order to allow for the direct
11 acceptance and payment of nursing home claims.

12 Notwithstanding any other law to the contrary, the
13 Illinois Department shall, within 365 days after August 15,
14 2014 (the effective date of Public Act 98-963), establish
15 procedures to permit ID/DD facilities licensed under the ID/DD
16 Community Care Act and MC/DD facilities licensed under the
17 MC/DD Act to submit monthly billing claims for reimbursement
18 purposes. Following development of these procedures, the
19 Department shall have an additional 365 days to test the
20 viability of the new system and to ensure that any necessary
21 operational or structural changes to its information
22 technology platforms are implemented.

23 The Illinois Department shall require all dispensers of
24 medical services, other than an individual practitioner or
25 group of practitioners, desiring to participate in the Medical
26 Assistance program established under this Article to disclose

1 all financial, beneficial, ownership, equity, surety or other
2 interests in any and all firms, corporations, partnerships,
3 associations, business enterprises, joint ventures, agencies,
4 institutions or other legal entities providing any form of
5 health care services in this State under this Article.

6 The Illinois Department may require that all dispensers of
7 medical services desiring to participate in the medical
8 assistance program established under this Article disclose,
9 under such terms and conditions as the Illinois Department may
10 by rule establish, all inquiries from clients and attorneys
11 regarding medical bills paid by the Illinois Department, which
12 inquiries could indicate potential existence of claims or
13 liens for the Illinois Department.

14 Enrollment of a vendor shall be subject to a provisional
15 period and shall be conditional for one year. During the
16 period of conditional enrollment, the Department may terminate
17 the vendor's eligibility to participate in, or may disenroll
18 the vendor from, the medical assistance program without cause.
19 Unless otherwise specified, such termination of eligibility or
20 disenrollment is not subject to the Department's hearing
21 process. However, a disenrolled vendor may reapply without
22 penalty.

23 The Department has the discretion to limit the conditional
24 enrollment period for vendors based upon the category of risk
25 of the vendor.

26 Prior to enrollment and during the conditional enrollment

1 period in the medical assistance program, all vendors shall be
2 subject to enhanced oversight, screening, and review based on
3 the risk of fraud, waste, and abuse that is posed by the
4 category of risk of the vendor. The Illinois Department shall
5 establish the procedures for oversight, screening, and review,
6 which may include, but need not be limited to: criminal and
7 financial background checks; fingerprinting; license,
8 certification, and authorization verifications; unscheduled or
9 unannounced site visits; database checks; prepayment audit
10 reviews; audits; payment caps; payment suspensions; and other
11 screening as required by federal or State law.

12 The Department shall define or specify the following: (i)
13 by provider notice, the "category of risk of the vendor" for
14 each type of vendor, which shall take into account the level of
15 screening applicable to a particular category of vendor under
16 federal law and regulations; (ii) by rule or provider notice,
17 the maximum length of the conditional enrollment period for
18 each category of risk of the vendor; and (iii) by rule, the
19 hearing rights, if any, afforded to a vendor in each category
20 of risk of the vendor that is terminated or disenrolled during
21 the conditional enrollment period.

22 To be eligible for payment consideration, a vendor's
23 payment claim or bill, either as an initial claim or as a
24 resubmitted claim following prior rejection, must be received
25 by the Illinois Department, or its fiscal intermediary, no
26 later than 180 days after the latest date on the claim on which

1 medical goods or services were provided, with the following
2 exceptions:

3 (1) In the case of a provider whose enrollment is in
4 process by the Illinois Department, the 180-day period
5 shall not begin until the date on the written notice from
6 the Illinois Department that the provider enrollment is
7 complete.

8 (2) In the case of errors attributable to the Illinois
9 Department or any of its claims processing intermediaries
10 which result in an inability to receive, process, or
11 adjudicate a claim, the 180-day period shall not begin
12 until the provider has been notified of the error.

13 (3) In the case of a provider for whom the Illinois
14 Department initiates the monthly billing process.

15 (4) In the case of a provider operated by a unit of
16 local government with a population exceeding 3,000,000
17 when local government funds finance federal participation
18 for claims payments.

19 For claims for services rendered during a period for which
20 a recipient received retroactive eligibility, claims must be
21 filed within 180 days after the Department determines the
22 applicant is eligible. For claims for which the Illinois
23 Department is not the primary payer, claims must be submitted
24 to the Illinois Department within 180 days after the final
25 adjudication by the primary payer.

26 In the case of long term care facilities, within 120

1 calendar days of receipt by the facility of required
2 prescreening information, new admissions with associated
3 admission documents shall be submitted through the Medical
4 Electronic Data Interchange (MEDI) or the Recipient
5 Eligibility Verification (REV) System or shall be submitted
6 directly to the Department of Human Services using required
7 admission forms. Effective September 1, 2014, admission
8 documents, including all prescreening information, must be
9 submitted through MEDI or REV. Confirmation numbers assigned
10 to an accepted transaction shall be retained by a facility to
11 verify timely submittal. Once an admission transaction has
12 been completed, all resubmitted claims following prior
13 rejection are subject to receipt no later than 180 days after
14 the admission transaction has been completed.

15 Claims that are not submitted and received in compliance
16 with the foregoing requirements shall not be eligible for
17 payment under the medical assistance program, and the State
18 shall have no liability for payment of those claims.

19 To the extent consistent with applicable information and
20 privacy, security, and disclosure laws, State and federal
21 agencies and departments shall provide the Illinois Department
22 access to confidential and other information and data
23 necessary to perform eligibility and payment verifications and
24 other Illinois Department functions. This includes, but is not
25 limited to: information pertaining to licensure;
26 certification; earnings; immigration status; citizenship; wage

1 reporting; unearned and earned income; pension income;
2 employment; supplemental security income; social security
3 numbers; National Provider Identifier (NPI) numbers; the
4 National Practitioner Data Bank (NPDB); program and agency
5 exclusions; taxpayer identification numbers; tax delinquency;
6 corporate information; and death records.

7 The Illinois Department shall enter into agreements with
8 State agencies and departments, and is authorized to enter
9 into agreements with federal agencies and departments, under
10 which such agencies and departments shall share data necessary
11 for medical assistance program integrity functions and
12 oversight. The Illinois Department shall develop, in
13 cooperation with other State departments and agencies, and in
14 compliance with applicable federal laws and regulations,
15 appropriate and effective methods to share such data. At a
16 minimum, and to the extent necessary to provide data sharing,
17 the Illinois Department shall enter into agreements with State
18 agencies and departments, and is authorized to enter into
19 agreements with federal agencies and departments, including,
20 but not limited to: the Secretary of State; the Department of
21 Revenue; the Department of Public Health; the Department of
22 Human Services; and the Department of Financial and
23 Professional Regulation.

24 Beginning in fiscal year 2013, the Illinois Department
25 shall set forth a request for information to identify the
26 benefits of a pre-payment, post-adjudication, and post-edit

1 claims system with the goals of streamlining claims processing
2 and provider reimbursement, reducing the number of pending or
3 rejected claims, and helping to ensure a more transparent
4 adjudication process through the utilization of: (i) provider
5 data verification and provider screening technology; and (ii)
6 clinical code editing; and (iii) pre-pay, pre-adjudicated ~~pre-~~
7 or post-adjudicated predictive modeling with an integrated
8 case management system with link analysis. Such a request for
9 information shall not be considered as a request for proposal
10 or as an obligation on the part of the Illinois Department to
11 take any action or acquire any products or services.

12 The Illinois Department shall establish policies,
13 procedures, standards and criteria by rule for the
14 acquisition, repair and replacement of orthotic and prosthetic
15 devices and durable medical equipment. Such rules shall
16 provide, but not be limited to, the following services: (1)
17 immediate repair or replacement of such devices by recipients;
18 and (2) rental, lease, purchase or lease-purchase of durable
19 medical equipment in a cost-effective manner, taking into
20 consideration the recipient's medical prognosis, the extent of
21 the recipient's needs, and the requirements and costs for
22 maintaining such equipment. Subject to prior approval, such
23 rules shall enable a recipient to temporarily acquire and use
24 alternative or substitute devices or equipment pending repairs
25 or replacements of any device or equipment previously
26 authorized for such recipient by the Department.

1 Notwithstanding any provision of Section 5-5f to the contrary,
2 the Department may, by rule, exempt certain replacement
3 wheelchair parts from prior approval and, for wheelchairs,
4 wheelchair parts, wheelchair accessories, and related seating
5 and positioning items, determine the wholesale price by
6 methods other than actual acquisition costs.

7 The Department shall require, by rule, all providers of
8 durable medical equipment to be accredited by an accreditation
9 organization approved by the federal Centers for Medicare and
10 Medicaid Services and recognized by the Department in order to
11 bill the Department for providing durable medical equipment to
12 recipients. No later than 15 months after the effective date
13 of the rule adopted pursuant to this paragraph, all providers
14 must meet the accreditation requirement.

15 In order to promote environmental responsibility, meet the
16 needs of recipients and enrollees, and achieve significant
17 cost savings, the Department, or a managed care organization
18 under contract with the Department, may provide recipients or
19 managed care enrollees who have a prescription or Certificate
20 of Medical Necessity access to refurbished durable medical
21 equipment under this Section (excluding prosthetic and
22 orthotic devices as defined in the Orthotics, Prosthetics, and
23 Pedorthics Practice Act and complex rehabilitation technology
24 products and associated services) through the State's
25 assistive technology program's reutilization program, using
26 staff with the Assistive Technology Professional (ATP)

1 Certification if the refurbished durable medical equipment:
2 (i) is available; (ii) is less expensive, including shipping
3 costs, than new durable medical equipment of the same type;
4 (iii) is able to withstand at least 3 years of use; (iv) is
5 cleaned, disinfected, sterilized, and safe in accordance with
6 federal Food and Drug Administration regulations and guidance
7 governing the reprocessing of medical devices in health care
8 settings; and (v) equally meets the needs of the recipient or
9 enrollee. The reutilization program shall confirm that the
10 recipient or enrollee is not already in receipt of the same or
11 similar equipment from another service provider, and that the
12 refurbished durable medical equipment equally meets the needs
13 of the recipient or enrollee. Nothing in this paragraph shall
14 be construed to limit recipient or enrollee choice to obtain
15 new durable medical equipment or place any additional prior
16 authorization conditions on enrollees of managed care
17 organizations.

18 The Department shall execute, relative to the nursing home
19 prescreening project, written inter-agency agreements with the
20 Department of Human Services and the Department on Aging, to
21 effect the following: (i) intake procedures and common
22 eligibility criteria for those persons who are receiving
23 non-institutional services; and (ii) the establishment and
24 development of non-institutional services in areas of the
25 State where they are not currently available or are
26 undeveloped; and (iii) notwithstanding any other provision of

1 law, subject to federal approval, on and after July 1, 2012, an
2 increase in the determination of need (DON) scores from 29 to
3 37 for applicants for institutional and home and
4 community-based long term care; if and only if federal
5 approval is not granted, the Department may, in conjunction
6 with other affected agencies, implement utilization controls
7 or changes in benefit packages to effectuate a similar savings
8 amount for this population; and (iv) no later than July 1,
9 2013, minimum level of care eligibility criteria for
10 institutional and home and community-based long term care; and
11 (v) no later than October 1, 2013, establish procedures to
12 permit long term care providers access to eligibility scores
13 for individuals with an admission date who are seeking or
14 receiving services from the long term care provider. In order
15 to select the minimum level of care eligibility criteria, the
16 Governor shall establish a workgroup that includes affected
17 agency representatives and stakeholders representing the
18 institutional and home and community-based long term care
19 interests. This Section shall not restrict the Department from
20 implementing lower level of care eligibility criteria for
21 community-based services in circumstances where federal
22 approval has been granted.

23 The Illinois Department shall develop and operate, in
24 cooperation with other State Departments and agencies and in
25 compliance with applicable federal laws and regulations,
26 appropriate and effective systems of health care evaluation

1 and programs for monitoring of utilization of health care
2 services and facilities, as it affects persons eligible for
3 medical assistance under this Code.

4 The Illinois Department shall report annually to the
5 General Assembly, no later than the second Friday in April of
6 1979 and each year thereafter, in regard to:

7 (a) actual statistics and trends in utilization of
8 medical services by public aid recipients;

9 (b) actual statistics and trends in the provision of
10 the various medical services by medical vendors;

11 (c) current rate structures and proposed changes in
12 those rate structures for the various medical vendors; and

13 (d) efforts at utilization review and control by the
14 Illinois Department.

15 The period covered by each report shall be the 3 years
16 ending on the June 30 prior to the report. The report shall
17 include suggested legislation for consideration by the General
18 Assembly. The requirement for reporting to the General
19 Assembly shall be satisfied by filing copies of the report as
20 required by Section 3.1 of the General Assembly Organization
21 Act, and filing such additional copies with the State
22 Government Report Distribution Center for the General Assembly
23 as is required under paragraph (t) of Section 7 of the State
24 Library Act.

25 Rulemaking authority to implement Public Act 95-1045, if
26 any, is conditioned on the rules being adopted in accordance

1 with all provisions of the Illinois Administrative Procedure
2 Act and all rules and procedures of the Joint Committee on
3 Administrative Rules; any purported rule not so adopted, for
4 whatever reason, is unauthorized.

5 On and after July 1, 2012, the Department shall reduce any
6 rate of reimbursement for services or other payments or alter
7 any methodologies authorized by this Code to reduce any rate
8 of reimbursement for services or other payments in accordance
9 with Section 5-5e.

10 Because kidney transplantation can be an appropriate,
11 cost-effective alternative to renal dialysis when medically
12 necessary and notwithstanding the provisions of Section 1-11
13 of this Code, beginning October 1, 2014, the Department shall
14 cover kidney transplantation for noncitizens with end-stage
15 renal disease who are not eligible for comprehensive medical
16 benefits, who meet the residency requirements of Section 5-3
17 of this Code, and who would otherwise meet the financial
18 requirements of the appropriate class of eligible persons
19 under Section 5-2 of this Code. To qualify for coverage of
20 kidney transplantation, such person must be receiving
21 emergency renal dialysis services covered by the Department.
22 Providers under this Section shall be prior approved and
23 certified by the Department to perform kidney transplantation
24 and the services under this Section shall be limited to
25 services associated with kidney transplantation.

26 Notwithstanding any other provision of this Code to the

1 contrary, on or after July 1, 2015, all FDA approved forms of
2 medication assisted treatment prescribed for the treatment of
3 alcohol dependence or treatment of opioid dependence shall be
4 covered under both fee for service and managed care medical
5 assistance programs for persons who are otherwise eligible for
6 medical assistance under this Article and shall not be subject
7 to any (1) utilization control, other than those established
8 under the American Society of Addiction Medicine patient
9 placement criteria, (2) prior authorization mandate, or (3)
10 lifetime restriction limit mandate.

11 On or after July 1, 2015, opioid antagonists prescribed
12 for the treatment of an opioid overdose, including the
13 medication product, administration devices, and any pharmacy
14 fees or hospital fees related to the dispensing, distribution,
15 and administration of the opioid antagonist, shall be covered
16 under the medical assistance program for persons who are
17 otherwise eligible for medical assistance under this Article.
18 As used in this Section, "opioid antagonist" means a drug that
19 binds to opioid receptors and blocks or inhibits the effect of
20 opioids acting on those receptors, including, but not limited
21 to, naloxone hydrochloride or any other similarly acting drug
22 approved by the U.S. Food and Drug Administration. The
23 Department shall not impose a copayment on the coverage
24 provided for naloxone hydrochloride under the medical
25 assistance program.

26 Upon federal approval, the Department shall provide

1 coverage and reimbursement for all drugs that are approved for
2 marketing by the federal Food and Drug Administration and that
3 are recommended by the federal Public Health Service or the
4 United States Centers for Disease Control and Prevention for
5 pre-exposure prophylaxis and related pre-exposure prophylaxis
6 services, including, but not limited to, HIV and sexually
7 transmitted infection screening, treatment for sexually
8 transmitted infections, medical monitoring, assorted labs, and
9 counseling to reduce the likelihood of HIV infection among
10 individuals who are not infected with HIV but who are at high
11 risk of HIV infection.

12 A federally qualified health center, as defined in Section
13 1905(1)(2)(B) of the federal Social Security Act, shall be
14 reimbursed by the Department in accordance with the federally
15 qualified health center's encounter rate for services provided
16 to medical assistance recipients that are performed by a
17 dental hygienist, as defined under the Illinois Dental
18 Practice Act, working under the general supervision of a
19 dentist and employed by a federally qualified health center.

20 Within 90 days after October 8, 2021 (the effective date
21 of Public Act 102-665), the Department shall seek federal
22 approval of a State Plan amendment to expand coverage for
23 family planning services that includes presumptive eligibility
24 to individuals whose income is at or below 208% of the federal
25 poverty level. Coverage under this Section shall be effective
26 beginning no later than December 1, 2022.

1 Subject to approval by the federal Centers for Medicare
2 and Medicaid Services of a Title XIX State Plan amendment
3 electing the Program of All-Inclusive Care for the Elderly
4 (PACE) as a State Medicaid option, as provided for by Subtitle
5 I (commencing with Section 4801) of Title IV of the Balanced
6 Budget Act of 1997 (Public Law 105-33) and Part 460
7 (commencing with Section 460.2) of Subchapter E of Title 42 of
8 the Code of Federal Regulations, PACE program services shall
9 become a covered benefit of the medical assistance program,
10 subject to criteria established in accordance with all
11 applicable laws.

12 Notwithstanding any other provision of this Code,
13 community-based pediatric palliative care from a trained
14 interdisciplinary team shall be covered under the medical
15 assistance program as provided in Section 15 of the Pediatric
16 Palliative Care Act.

17 Notwithstanding any other provision of this Code, within
18 12 months after June 2, 2022 (the effective date of Public Act
19 102-1037) ~~this amendatory Act of the 102nd General Assembly~~
20 and subject to federal approval, acupuncture services
21 performed by an acupuncturist licensed under the Acupuncture
22 Practice Act who is acting within the scope of his or her
23 license shall be covered under the medical assistance program.
24 The Department shall apply for any federal waiver or State
25 Plan amendment, if required, to implement this paragraph. The
26 Department may adopt any rules, including standards and

1 criteria, necessary to implement this paragraph.

2 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;
3 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article
4 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section
5 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;
6 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.
7 1-1-22; 102-665, eff. 10-8-21; 102-813, eff. 5-13-22;
8 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22; 102-1038 eff.
9 1-1-23; revised 2-5-23.)

10 (305 ILCS 5/12-8) (from Ch. 23, par. 12-8)

11 Sec. 12-8. Public Assistance Emergency Revolving Fund -
12 Uses. The Public Assistance Emergency Revolving Fund,
13 established by Act approved July 8, 1955 shall be held by the
14 Illinois Department and shall be used for the following
15 purposes:

16 1. To provide immediate financial aid to applicants in
17 acute need who have been determined eligible for aid under
18 Articles III, IV, or V.

19 2. To provide emergency aid to recipients under said
20 Articles who have failed to receive their grants because
21 of mail box or other thefts, or who are victims of a
22 burnout, eviction, or other circumstances causing
23 privation, in which cases the delays incident to the
24 issuance of grants from appropriations would cause
25 hardship and suffering.

1 3. To provide emergency aid for transportation, meals
2 and lodging to applicants who are referred to cities other
3 than where they reside for physical examinations to
4 establish blindness or disability, or to determine the
5 incapacity of the parent of a dependent child.

6 4. To provide emergency transportation expense
7 allowances to recipients engaged in vocational training
8 and rehabilitation projects.

9 5. To assist public aid applicants in obtaining copies
10 of birth certificates, death certificates, marriage
11 licenses or other similar legal documents which may
12 facilitate the verification of eligibility for public aid
13 under this Code.

14 6. To provide immediate payments to current or former
15 recipients of child support enforcement services, or
16 refunds to responsible relatives, for child support made
17 to the Illinois Department under Title IV-D of the Social
18 Security Act when such recipients of services or
19 responsible relatives are legally entitled to all or part
20 of such child support payments under applicable State or
21 federal law.

22 7. To provide payments to individuals or providers of
23 transportation to and from medical care for the benefit of
24 recipients under Articles III, IV, V, and VI.

25 8. To provide immediate payment of fees, as follows:

26 (A) To sheriffs and other public officials

1 authorized by law to serve process in judicial and
2 administrative child support actions in the State of
3 Illinois and other states.

4 (B) To county clerks, recorders of deeds, and
5 other public officials and keepers of real property
6 records in order to perfect and release real property
7 liens.

8 (C) To State and local officials in connection
9 with the processing of Qualified Illinois Domestic
10 Relations Orders.

11 (D) To the State Registrar of Vital Records, local
12 registrars of vital records, or other public officials
13 and keepers of voluntary acknowledgment of paternity
14 forms.

15 Disbursements from the Public Assistance Emergency
16 Revolving Fund shall be made by the Illinois Department.

17 Expenditures from the Public Assistance Emergency
18 Revolving Fund shall be for purposes which are properly
19 chargeable to appropriations made to the Illinois Department,
20 or, in the case of payments under subparagraphs 6 and 8, to the
21 Child Support Enforcement Trust Fund or the Child Support
22 Administrative Fund, except that no expenditure, other than
23 payment of the fees provided for under subparagraph 8 of this
24 Section, shall be made for purposes which are properly
25 chargeable to appropriations for the following objects:
26 personal services; extra help; state contributions to

1 retirement system; state contributions to Social Security;
2 state contributions for employee group insurance; contractual
3 services; travel; commodities; printing; equipment; electronic
4 data processing; operation of auto equipment;
5 telecommunications services; library books; and refunds. The
6 Illinois Department shall reimburse the Public Assistance
7 Emergency Revolving Fund by warrants drawn by the State
8 Comptroller on the appropriation or appropriations which are
9 so chargeable, or, in the case of payments under subparagraphs
10 6 and 8, by warrants drawn on the Child Support Enforcement
11 Trust Fund or the Child Support Administrative Fund, payable
12 to the Revolving Fund.

13 (Source: P.A. 97-735, eff. 7-3-12.)

14 ARTICLE 100.

15 Section 100-5. The Illinois Public Aid Code is amended by
16 changing Section 5-5.01a as follows:

17 (305 ILCS 5/5-5.01a)

18 Sec. 5-5.01a. Supportive living facilities program.

19 (a) The Department shall establish and provide oversight
20 for a program of supportive living facilities that seek to
21 promote resident independence, dignity, respect, and
22 well-being in the most cost-effective manner.

23 A supportive living facility is (i) a free-standing

1 facility or (ii) a distinct physical and operational entity
2 within a mixed-use building that meets the criteria
3 established in subsection (d). A supportive living facility
4 integrates housing with health, personal care, and supportive
5 services and is a designated setting that offers residents
6 their own separate, private, and distinct living units.

7 Sites for the operation of the program shall be selected
8 by the Department based upon criteria that may include the
9 need for services in a geographic area, the availability of
10 funding, and the site's ability to meet the standards.

11 (b) Beginning July 1, 2014, subject to federal approval,
12 the Medicaid rates for supportive living facilities shall be
13 equal to the supportive living facility Medicaid rate
14 effective on June 30, 2014 increased by 8.85%. Once the
15 assessment imposed at Article V-G of this Code is determined
16 to be a permissible tax under Title XIX of the Social Security
17 Act, the Department shall increase the Medicaid rates for
18 supportive living facilities effective on July 1, 2014 by
19 9.09%. The Department shall apply this increase retroactively
20 to coincide with the imposition of the assessment in Article
21 V-G of this Code in accordance with the approval for federal
22 financial participation by the Centers for Medicare and
23 Medicaid Services.

24 The Medicaid rates for supportive living facilities
25 effective on July 1, 2017 must be equal to the rates in effect
26 for supportive living facilities on June 30, 2017 increased by

1 2.8%.

2 The Medicaid rates for supportive living facilities
3 effective on July 1, 2018 must be equal to the rates in effect
4 for supportive living facilities on June 30, 2018.

5 Subject to federal approval, the Medicaid rates for
6 supportive living services on and after July 1, 2019 must be at
7 least 54.3% of the average total nursing facility services per
8 diem for the geographic areas defined by the Department while
9 maintaining the rate differential for dementia care and must
10 be updated whenever the total nursing facility service per
11 diems are updated. Beginning July 1, 2022, upon the
12 implementation of the Patient Driven Payment Model, Medicaid
13 rates for supportive living services must be at least 54.3% of
14 the average total nursing services per diem rate for the
15 geographic areas. For purposes of this provision, the average
16 total nursing services per diem rate shall include all add-ons
17 for nursing facilities for the geographic area provided for in
18 Section 5-5.2. The rate differential for dementia care must be
19 maintained in these rates and the rates shall be updated
20 whenever nursing facility per diem rates are updated.

21 (c) The Department may adopt rules to implement this
22 Section. Rules that establish or modify the services,
23 standards, and conditions for participation in the program
24 shall be adopted by the Department in consultation with the
25 Department on Aging, the Department of Rehabilitation
26 Services, and the Department of Mental Health and

1 Developmental Disabilities (or their successor agencies).

2 (d) Subject to federal approval by the Centers for
3 Medicare and Medicaid Services, the Department shall accept
4 for consideration of certification under the program any
5 application for a site or building where distinct parts of the
6 site or building are designated for purposes other than the
7 provision of supportive living services, but only if:

8 (1) those distinct parts of the site or building are
9 not designated for the purpose of providing assisted
10 living services as required under the Assisted Living and
11 Shared Housing Act;

12 (2) those distinct parts of the site or building are
13 completely separate from the part of the building used for
14 the provision of supportive living program services,
15 including separate entrances;

16 (3) those distinct parts of the site or building do
17 not share any common spaces with the part of the building
18 used for the provision of supportive living program
19 services; and

20 (4) those distinct parts of the site or building do
21 not share staffing with the part of the building used for
22 the provision of supportive living program services.

23 (e) Facilities or distinct parts of facilities which are
24 selected as supportive living facilities and are in good
25 standing with the Department's rules are exempt from the
26 provisions of the Nursing Home Care Act and the Illinois

1 Health Facilities Planning Act.

2 (f) Section 9817 of the American Rescue Plan Act of 2021
3 (Public Law 117-2) authorizes a 10% enhanced federal medical
4 assistance percentage for supportive living services for a
5 12-month period from April 1, 2021 through March 31, 2022.
6 Subject to federal approval, including the approval of any
7 necessary waiver amendments or other federally required
8 documents or assurances, for a 12-month period the Department
9 must pay a supplemental \$26 per diem rate to all supportive
10 living facilities with the additional federal financial
11 participation funds that result from the enhanced federal
12 medical assistance percentage from April 1, 2021 through March
13 31, 2022. The Department may issue parameters around how the
14 supplemental payment should be spent, including quality
15 improvement activities. The Department may alter the form,
16 methods, or timeframes concerning the supplemental per diem
17 rate to comply with any subsequent changes to federal law,
18 changes made by guidance issued by the federal Centers for
19 Medicare and Medicaid Services, or other changes necessary to
20 receive the enhanced federal medical assistance percentage.

21 (g) All applications for the expansion of supportive
22 living dementia care settings involving sites not approved by
23 the Department on the effective date of this amendatory Act of
24 the 103rd General Assembly may allow new elderly non-dementia
25 units in addition to new dementia care units. The Department
26 may approve such applications only if the application has: (1)

1 no more than one non-dementia care unit for each dementia care
2 unit and (2) the site is not located within 4 miles of an
3 existing supportive living program site in Cook County
4 (including the City of Chicago), not located within 12 miles
5 of an existing supportive living program site in DuPage
6 County, Kane County, Lake County, McHenry County, or Will
7 County, or not located within 25 miles of an existing
8 supportive living program site in any other county.

9 (Source: P.A. 101-10, eff. 6-5-19; 102-43, eff. 7-6-21;
10 102-699, eff. 4-19-22.)

11 ARTICLE 105.

12 Section 105-5. The Illinois Public Aid Code is amended by
13 changing Section 5A-2 as follows:

14 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

15 (Section scheduled to be repealed on December 31, 2026)

16 Sec. 5A-2. Assessment.

17 (a)(1) Subject to Sections 5A-3 and 5A-10, for State
18 fiscal years 2009 through 2018, or as long as continued under
19 Section 5A-16, an annual assessment on inpatient services is
20 imposed on each hospital provider in an amount equal to
21 \$218.38 multiplied by the difference of the hospital's
22 occupied bed days less the hospital's Medicare bed days,
23 provided, however, that the amount of \$218.38 shall be

1 increased by a uniform percentage to generate an amount equal
2 to 75% of the State share of the payments authorized under
3 Section 5A-12.5, with such increase only taking effect upon
4 the date that a State share for such payments is required under
5 federal law. For the period of April through June 2015, the
6 amount of \$218.38 used to calculate the assessment under this
7 paragraph shall, by emergency rule under subsection (s) of
8 Section 5-45 of the Illinois Administrative Procedure Act, be
9 increased by a uniform percentage to generate \$20,250,000 in
10 the aggregate for that period from all hospitals subject to
11 the annual assessment under this paragraph.

12 (2) In addition to any other assessments imposed under
13 this Article, effective July 1, 2016 and semi-annually
14 thereafter through June 2018, or as provided in Section 5A-16,
15 in addition to any federally required State share as
16 authorized under paragraph (1), the amount of \$218.38 shall be
17 increased by a uniform percentage to generate an amount equal
18 to 75% of the ACA Assessment Adjustment, as defined in
19 subsection (b-6) of this Section.

20 For State fiscal years 2009 through 2018, or as provided
21 in Section 5A-16, a hospital's occupied bed days and Medicare
22 bed days shall be determined using the most recent data
23 available from each hospital's 2005 Medicare cost report as
24 contained in the Healthcare Cost Report Information System
25 file, for the quarter ending on December 31, 2006, without
26 regard to any subsequent adjustments or changes to such data.

1 If a hospital's 2005 Medicare cost report is not contained in
2 the Healthcare Cost Report Information System, then the
3 Illinois Department may obtain the hospital provider's
4 occupied bed days and Medicare bed days from any source
5 available, including, but not limited to, records maintained
6 by the hospital provider, which may be inspected at all times
7 during business hours of the day by the Illinois Department or
8 its duly authorized agents and employees.

9 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
10 fiscal years 2019 and 2020, an annual assessment on inpatient
11 services is imposed on each hospital provider in an amount
12 equal to \$197.19 multiplied by the difference of the
13 hospital's occupied bed days less the hospital's Medicare bed
14 days. For State fiscal years 2019 and 2020, a hospital's
15 occupied bed days and Medicare bed days shall be determined
16 using the most recent data available from each hospital's 2015
17 Medicare cost report as contained in the Healthcare Cost
18 Report Information System file, for the quarter ending on
19 March 31, 2017, without regard to any subsequent adjustments
20 or changes to such data. If a hospital's 2015 Medicare cost
21 report is not contained in the Healthcare Cost Report
22 Information System, then the Illinois Department may obtain
23 the hospital provider's occupied bed days and Medicare bed
24 days from any source available, including, but not limited to,
25 records maintained by the hospital provider, which may be
26 inspected at all times during business hours of the day by the

1 Illinois Department or its duly authorized agents and
2 employees. Notwithstanding any other provision in this
3 Article, for a hospital provider that did not have a 2015
4 Medicare cost report, but paid an assessment in State fiscal
5 year 2018 on the basis of hypothetical data, that assessment
6 amount shall be used for State fiscal years 2019 and 2020.

7 (4) Subject to Sections 5A-3 and 5A-10 and to subsection
8 (b-8), for the period of July 1, 2020 through December 31, 2020
9 and calendar years 2021 through 2026, an annual assessment on
10 inpatient services is imposed on each hospital provider in an
11 amount equal to \$221.50 multiplied by the difference of the
12 hospital's occupied bed days less the hospital's Medicare bed
13 days, provided however: for the period of July 1, 2020 through
14 December 31, 2020, (i) the assessment shall be equal to 50% of
15 the annual amount; and (ii) the amount of \$221.50 shall be
16 retroactively adjusted by a uniform percentage to generate an
17 amount equal to 50% of the Assessment Adjustment, as defined
18 in subsection (b-7). For the period of July 1, 2020 through
19 December 31, 2020 and calendar years 2021 through 2026, a
20 hospital's occupied bed days and Medicare bed days shall be
21 determined using the most recent data available from each
22 hospital's 2015 Medicare cost report as contained in the
23 Healthcare Cost Report Information System file, for the
24 quarter ending on March 31, 2017, without regard to any
25 subsequent adjustments or changes to such data. If a
26 hospital's 2015 Medicare cost report is not contained in the

1 Healthcare Cost Report Information System, then the Illinois
2 Department may obtain the hospital provider's occupied bed
3 days and Medicare bed days from any source available,
4 including, but not limited to, records maintained by the
5 hospital provider, which may be inspected at all times during
6 business hours of the day by the Illinois Department or its
7 duly authorized agents and employees. Should the change in the
8 assessment methodology for fiscal years 2021 through December
9 31, 2022 not be approved on or before June 30, 2020, the
10 assessment and payments under this Article in effect for
11 fiscal year 2020 shall remain in place until the new
12 assessment is approved. If the assessment methodology for July
13 1, 2020 through December 31, 2022, is approved on or after July
14 1, 2020, it shall be retroactive to July 1, 2020, subject to
15 federal approval and provided that the payments authorized
16 under Section 5A-12.7 have the same effective date as the new
17 assessment methodology. In giving retroactive effect to the
18 assessment approved after June 30, 2020, credit toward the new
19 assessment shall be given for any payments of the previous
20 assessment for periods after June 30, 2020. Notwithstanding
21 any other provision of this Article, for a hospital provider
22 that did not have a 2015 Medicare cost report, but paid an
23 assessment in State Fiscal Year 2020 on the basis of
24 hypothetical data, the data that was the basis for the 2020
25 assessment shall be used to calculate the assessment under
26 this paragraph until December 31, 2023. Beginning July 1, 2022

1 and through December 31, 2024, a safety-net hospital that had
2 a change of ownership in calendar year 2021, and whose
3 inpatient utilization had decreased by 90% from the prior year
4 and prior to the change of ownership, may be eligible to pay a
5 tax based on hypothetical data based on a determination of
6 financial distress by the Department. Subject to federal
7 approval, the Department may, by January 1, 2024, develop a
8 hypothetical tax for a specialty cancer hospital which had a
9 structural change of ownership during calendar year 2022 from
10 a for-profit entity to a non-profit entity, and which has
11 experienced a decline of 60% or greater in inpatient days of
12 care as compared to the prior owners 2015 Medicare cost
13 report. This change of ownership may make the hospital
14 eligible for a hypothetical tax under the new hospital
15 provision of the assessment defined in this Section. This new
16 hypothetical tax may be applicable from January 1, 2024
17 through December 31, 2026.

18 (b) (Blank).

19 (b-5)(1) Subject to Sections 5A-3 and 5A-10, for the
20 portion of State fiscal year 2012, beginning June 10, 2012
21 through June 30, 2012, and for State fiscal years 2013 through
22 2018, or as provided in Section 5A-16, an annual assessment on
23 outpatient services is imposed on each hospital provider in an
24 amount equal to .008766 multiplied by the hospital's
25 outpatient gross revenue, provided, however, that the amount
26 of .008766 shall be increased by a uniform percentage to

1 generate an amount equal to 25% of the State share of the
2 payments authorized under Section 5A-12.5, with such increase
3 only taking effect upon the date that a State share for such
4 payments is required under federal law. For the period
5 beginning June 10, 2012 through June 30, 2012, the annual
6 assessment on outpatient services shall be prorated by
7 multiplying the assessment amount by a fraction, the numerator
8 of which is 21 days and the denominator of which is 365 days.
9 For the period of April through June 2015, the amount of
10 .008766 used to calculate the assessment under this paragraph
11 shall, by emergency rule under subsection (s) of Section 5-45
12 of the Illinois Administrative Procedure Act, be increased by
13 a uniform percentage to generate \$6,750,000 in the aggregate
14 for that period from all hospitals subject to the annual
15 assessment under this paragraph.

16 (2) In addition to any other assessments imposed under
17 this Article, effective July 1, 2016 and semi-annually
18 thereafter through June 2018, in addition to any federally
19 required State share as authorized under paragraph (1), the
20 amount of .008766 shall be increased by a uniform percentage
21 to generate an amount equal to 25% of the ACA Assessment
22 Adjustment, as defined in subsection (b-6) of this Section.

23 For the portion of State fiscal year 2012, beginning June
24 10, 2012 through June 30, 2012, and State fiscal years 2013
25 through 2018, or as provided in Section 5A-16, a hospital's
26 outpatient gross revenue shall be determined using the most

1 recent data available from each hospital's 2009 Medicare cost
2 report as contained in the Healthcare Cost Report Information
3 System file, for the quarter ending on June 30, 2011, without
4 regard to any subsequent adjustments or changes to such data.
5 If a hospital's 2009 Medicare cost report is not contained in
6 the Healthcare Cost Report Information System, then the
7 Department may obtain the hospital provider's outpatient gross
8 revenue from any source available, including, but not limited
9 to, records maintained by the hospital provider, which may be
10 inspected at all times during business hours of the day by the
11 Department or its duly authorized agents and employees.

12 (3) Subject to Sections 5A-3, 5A-10, and 5A-16, for State
13 fiscal years 2019 and 2020, an annual assessment on outpatient
14 services is imposed on each hospital provider in an amount
15 equal to .01358 multiplied by the hospital's outpatient gross
16 revenue. For State fiscal years 2019 and 2020, a hospital's
17 outpatient gross revenue shall be determined using the most
18 recent data available from each hospital's 2015 Medicare cost
19 report as contained in the Healthcare Cost Report Information
20 System file, for the quarter ending on March 31, 2017, without
21 regard to any subsequent adjustments or changes to such data.
22 If a hospital's 2015 Medicare cost report is not contained in
23 the Healthcare Cost Report Information System, then the
24 Department may obtain the hospital provider's outpatient gross
25 revenue from any source available, including, but not limited
26 to, records maintained by the hospital provider, which may be

1 inspected at all times during business hours of the day by the
2 Department or its duly authorized agents and employees.
3 Notwithstanding any other provision in this Article, for a
4 hospital provider that did not have a 2015 Medicare cost
5 report, but paid an assessment in State fiscal year 2018 on the
6 basis of hypothetical data, that assessment amount shall be
7 used for State fiscal years 2019 and 2020.

8 (4) Subject to Sections 5A-3 and 5A-10 and to subsection
9 (b-8), for the period of July 1, 2020 through December 31, 2020
10 and calendar years 2021 through 2026, an annual assessment on
11 outpatient services is imposed on each hospital provider in an
12 amount equal to .01525 multiplied by the hospital's outpatient
13 gross revenue, provided however: (i) for the period of July 1,
14 2020 through December 31, 2020, the assessment shall be equal
15 to 50% of the annual amount; and (ii) the amount of .01525
16 shall be retroactively adjusted by a uniform percentage to
17 generate an amount equal to 50% of the Assessment Adjustment,
18 as defined in subsection (b-7). For the period of July 1, 2020
19 through December 31, 2020 and calendar years 2021 through
20 2026, a hospital's outpatient gross revenue shall be
21 determined using the most recent data available from each
22 hospital's 2015 Medicare cost report as contained in the
23 Healthcare Cost Report Information System file, for the
24 quarter ending on March 31, 2017, without regard to any
25 subsequent adjustments or changes to such data. If a
26 hospital's 2015 Medicare cost report is not contained in the

1 Healthcare Cost Report Information System, then the Illinois
2 Department may obtain the hospital provider's outpatient
3 revenue data from any source available, including, but not
4 limited to, records maintained by the hospital provider, which
5 may be inspected at all times during business hours of the day
6 by the Illinois Department or its duly authorized agents and
7 employees. Should the change in the assessment methodology
8 above for fiscal years 2021 through calendar year 2022 not be
9 approved prior to July 1, 2020, the assessment and payments
10 under this Article in effect for fiscal year 2020 shall remain
11 in place until the new assessment is approved. If the change in
12 the assessment methodology above for July 1, 2020 through
13 December 31, 2022, is approved after June 30, 2020, it shall
14 have a retroactive effective date of July 1, 2020, subject to
15 federal approval and provided that the payments authorized
16 under Section 12A-7 have the same effective date as the new
17 assessment methodology. In giving retroactive effect to the
18 assessment approved after June 30, 2020, credit toward the new
19 assessment shall be given for any payments of the previous
20 assessment for periods after June 30, 2020. Notwithstanding
21 any other provision of this Article, for a hospital provider
22 that did not have a 2015 Medicare cost report, but paid an
23 assessment in State Fiscal Year 2020 on the basis of
24 hypothetical data, the data that was the basis for the 2020
25 assessment shall be used to calculate the assessment under
26 this paragraph until December 31, 2023. Beginning July 1, 2022

1 and through December 31, 2024, a safety-net hospital that had
2 a change of ownership in calendar year 2021, and whose
3 inpatient utilization had decreased by 90% from the prior year
4 and prior to the change of ownership, may be eligible to pay a
5 tax based on hypothetical data based on a determination of
6 financial distress by the Department.

7 (b-6) (1) As used in this Section, "ACA Assessment
8 Adjustment" means:

9 (A) For the period of July 1, 2016 through December
10 31, 2016, the product of .19125 multiplied by the sum of
11 the fee-for-service payments to hospitals as authorized
12 under Section 5A-12.5 and the adjustments authorized under
13 subsection (t) of Section 5A-12.2 to managed care
14 organizations for hospital services due and payable in the
15 month of April 2016 multiplied by 6.

16 (B) For the period of January 1, 2017 through June 30,
17 2017, the product of .19125 multiplied by the sum of the
18 fee-for-service payments to hospitals as authorized under
19 Section 5A-12.5 and the adjustments authorized under
20 subsection (t) of Section 5A-12.2 to managed care
21 organizations for hospital services due and payable in the
22 month of October 2016 multiplied by 6, except that the
23 amount calculated under this subparagraph (B) shall be
24 adjusted, either positively or negatively, to account for
25 the difference between the actual payments issued under
26 Section 5A-12.5 for the period beginning July 1, 2016

1 through December 31, 2016 and the estimated payments due
2 and payable in the month of April 2016 multiplied by 6 as
3 described in subparagraph (A).

4 (C) For the period of July 1, 2017 through December
5 31, 2017, the product of .19125 multiplied by the sum of
6 the fee-for-service payments to hospitals as authorized
7 under Section 5A-12.5 and the adjustments authorized under
8 subsection (t) of Section 5A-12.2 to managed care
9 organizations for hospital services due and payable in the
10 month of April 2017 multiplied by 6, except that the
11 amount calculated under this subparagraph (C) shall be
12 adjusted, either positively or negatively, to account for
13 the difference between the actual payments issued under
14 Section 5A-12.5 for the period beginning January 1, 2017
15 through June 30, 2017 and the estimated payments due and
16 payable in the month of October 2016 multiplied by 6 as
17 described in subparagraph (B).

18 (D) For the period of January 1, 2018 through June 30,
19 2018, the product of .19125 multiplied by the sum of the
20 fee-for-service payments to hospitals as authorized under
21 Section 5A-12.5 and the adjustments authorized under
22 subsection (t) of Section 5A-12.2 to managed care
23 organizations for hospital services due and payable in the
24 month of October 2017 multiplied by 6, except that:

25 (i) the amount calculated under this subparagraph

26 (D) shall be adjusted, either positively or

1 negatively, to account for the difference between the
2 actual payments issued under Section 5A-12.5 for the
3 period of July 1, 2017 through December 31, 2017 and
4 the estimated payments due and payable in the month of
5 April 2017 multiplied by 6 as described in
6 subparagraph (C); and

7 (ii) the amount calculated under this subparagraph
8 (D) shall be adjusted to include the product of .19125
9 multiplied by the sum of the fee-for-service payments,
10 if any, estimated to be paid to hospitals under
11 subsection (b) of Section 5A-12.5.

12 (2) The Department shall complete and apply a final
13 reconciliation of the ACA Assessment Adjustment prior to June
14 30, 2018 to account for:

15 (A) any differences between the actual payments issued
16 or scheduled to be issued prior to June 30, 2018 as
17 authorized in Section 5A-12.5 for the period of January 1,
18 2018 through June 30, 2018 and the estimated payments due
19 and payable in the month of October 2017 multiplied by 6 as
20 described in subparagraph (D); and

21 (B) any difference between the estimated
22 fee-for-service payments under subsection (b) of Section
23 5A-12.5 and the amount of such payments that are actually
24 scheduled to be paid.

25 The Department shall notify hospitals of any additional
26 amounts owed or reduction credits to be applied to the June

1 2018 ACA Assessment Adjustment. This is to be considered the
2 final reconciliation for the ACA Assessment Adjustment.

3 (3) Notwithstanding any other provision of this Section,
4 if for any reason the scheduled payments under subsection (b)
5 of Section 5A-12.5 are not issued in full by the final day of
6 the period authorized under subsection (b) of Section 5A-12.5,
7 funds collected from each hospital pursuant to subparagraph
8 (D) of paragraph (1) and pursuant to paragraph (2),
9 attributable to the scheduled payments authorized under
10 subsection (b) of Section 5A-12.5 that are not issued in full
11 by the final day of the period attributable to each payment
12 authorized under subsection (b) of Section 5A-12.5, shall be
13 refunded.

14 (4) The increases authorized under paragraph (2) of
15 subsection (a) and paragraph (2) of subsection (b-5) shall be
16 limited to the federally required State share of the total
17 payments authorized under Section 5A-12.5 if the sum of such
18 payments yields an annualized amount equal to or less than
19 \$450,000,000, or if the adjustments authorized under
20 subsection (t) of Section 5A-12.2 are found not to be
21 actuarially sound; however, this limitation shall not apply to
22 the fee-for-service payments described in subsection (b) of
23 Section 5A-12.5.

24 (b-7)(1) As used in this Section, "Assessment Adjustment"
25 means:

26 (A) For the period of July 1, 2020 through December

1 31, 2020, the product of .3853 multiplied by the total of
2 the actual payments made under subsections (c) through (k)
3 of Section 5A-12.7 attributable to the period, less the
4 total of the assessment imposed under subsections (a) and
5 (b-5) of this Section for the period.

6 (B) For each calendar quarter beginning January 1,
7 2021 through December 31, 2022, the product of .3853
8 multiplied by the total of the actual payments made under
9 subsections (c) through (k) of Section 5A-12.7
10 attributable to the period, less the total of the
11 assessment imposed under subsections (a) and (b-5) of this
12 Section for the period.

13 (C) Beginning on January 1, 2023, and each subsequent
14 July 1 and January 1, the product of .3853 multiplied by
15 the total of the actual payments made under subsections
16 (c) through (j) of Section 5A-12.7 attributable to the
17 6-month period immediately preceding the period to which
18 the adjustment applies, less the total of the assessment
19 imposed under subsections (a) and (b-5) of this Section
20 for the 6-month period immediately preceding the period to
21 which the adjustment applies.

22 (2) The Department shall calculate and notify each
23 hospital of the total Assessment Adjustment and any additional
24 assessment owed by the hospital or refund owed to the hospital
25 on either a semi-annual or annual basis. Such notice shall be
26 issued at least 30 days prior to any period in which the

1 assessment will be adjusted. Any additional assessment owed by
2 the hospital or refund owed to the hospital shall be uniformly
3 applied to the assessment owed by the hospital in monthly
4 installments for the subsequent semi-annual period or calendar
5 year. If no assessment is owed in the subsequent year, any
6 amount owed by the hospital or refund due to the hospital,
7 shall be paid in a lump sum.

8 (3) The Department shall publish all details of the
9 Assessment Adjustment calculation performed each year on its
10 website within 30 days of completing the calculation, and also
11 submit the details of the Assessment Adjustment calculation as
12 part of the Department's annual report to the General
13 Assembly.

14 (b-8) Notwithstanding any other provision of this Article,
15 the Department shall reduce the assessments imposed on each
16 hospital under subsections (a) and (b-5) by the uniform
17 percentage necessary to reduce the total assessment imposed on
18 all hospitals by an aggregate amount of \$240,000,000, with
19 such reduction being applied by June 30, 2022. The assessment
20 reduction required for each hospital under this subsection
21 shall be forever waived, forgiven, and released by the
22 Department.

23 (c) (Blank).

24 (d) Notwithstanding any of the other provisions of this
25 Section, the Department is authorized to adopt rules to reduce
26 the rate of any annual assessment imposed under this Section,

1 as authorized by Section 5-46.2 of the Illinois Administrative
2 Procedure Act.

3 (e) Notwithstanding any other provision of this Section,
4 any plan providing for an assessment on a hospital provider as
5 a permissible tax under Title XIX of the federal Social
6 Security Act and Medicaid-eligible payments to hospital
7 providers from the revenues derived from that assessment shall
8 be reviewed by the Illinois Department of Healthcare and
9 Family Services, as the Single State Medicaid Agency required
10 by federal law, to determine whether those assessments and
11 hospital provider payments meet federal Medicaid standards. If
12 the Department determines that the elements of the plan may
13 meet federal Medicaid standards and a related State Medicaid
14 Plan Amendment is prepared in a manner and form suitable for
15 submission, that State Plan Amendment shall be submitted in a
16 timely manner for review by the Centers for Medicare and
17 Medicaid Services of the United States Department of Health
18 and Human Services and subject to approval by the Centers for
19 Medicare and Medicaid Services of the United States Department
20 of Health and Human Services. No such plan shall become
21 effective without approval by the Illinois General Assembly by
22 the enactment into law of related legislation. Notwithstanding
23 any other provision of this Section, the Department is
24 authorized to adopt rules to reduce the rate of any annual
25 assessment imposed under this Section. Any such rules may be
26 adopted by the Department under Section 5-50 of the Illinois

1 Administrative Procedure Act.

2 (Source: P.A. 101-10, eff. 6-5-19; 101-650, eff. 7-7-20;
3 reenacted by P.A. 101-655, eff. 3-12-21; 102-886, eff.
4 5-17-22.)

5 ARTICLE 110.

6 Section 110-5. The Illinois Insurance Code is amended by
7 adding Section 513b7 as follows:

8 (215 ILCS 5/513b7 new)

9 Sec. 513b7. Pharmacy audits.

10 (a) As used in this Section:

11 "Audit" means any physical on-site, remote electronic, or
12 concurrent review of a pharmacist or pharmacy service
13 submitted to the pharmacy benefit manager or pharmacy benefit
14 manager affiliate by a pharmacist or pharmacy for payment.

15 "Auditing entity" means a person or company that performs
16 a pharmacy audit.

17 "Extrapolation" means the practice of inferring a
18 frequency of dollar amount of overpayments, underpayments,
19 nonvalid claims, or other errors on any portion of claims
20 submitted, based on the frequency of dollar amount of
21 overpayments, underpayments, nonvalid claims, or other errors
22 actually measured in a sample of claims.

23 "Misfill" means a prescription that was not dispensed; a

1 prescription that was dispensed but was an incorrect dose,
2 amount, or type of medication; a prescription that was
3 dispensed to the wrong person; a prescription in which the
4 prescriber denied the authorization request; or a prescription
5 in which an additional dispensing fee was charged.

6 "Pharmacy audit" means an audit conducted of any records
7 of a pharmacy for prescriptions dispensed or nonproprietary
8 drugs or pharmacist services provided by a pharmacy or
9 pharmacist to a covered person.

10 "Pharmacy record" means any record stored electronically
11 or as a hard copy by a pharmacy that relates to the provision
12 of a prescription or pharmacy services or other component of
13 pharmacist care that is included in the practice of pharmacy.

14 (b) Notwithstanding any other law, when conducting a
15 pharmacy audit, an auditing entity shall:

16 (1) not conduct an on-site audit of a pharmacy at any
17 time during the first 3 business days of a month or the
18 first 2 weeks and final 2 weeks of the calendar year or
19 during a declared State or federal public health
20 emergency;

21 (2) notify the pharmacy or its contracting agent no
22 later than 14 business days before the date of initial
23 on-site audit; the notification to the pharmacy or its
24 contracting agent shall be in writing and delivered
25 either:

26 (A) by mail or common carrier, return receipt

1 requested; or

2 (B) electronically, not including facsimile, with
3 electronic receipt confirmation and delivered during
4 normal business hours of operation, addressed to the
5 supervising pharmacist and pharmacy corporate office,
6 if applicable, at least 14 business days before the
7 date of an initial on-site audit;

8 (3) limit the audit period to 24 months after the date
9 a claim is submitted to or adjudicated by the pharmacy
10 benefit manager;

11 (4) provide in writing the list of specific
12 prescription numbers to be included in the audit 14
13 business days before the on-site audit that may or may not
14 include the final 2 digits of the prescription numbers;

15 (5) use the written and verifiable records of a
16 hospital, physician, or other authorized practitioner that
17 are transmitted by any means of communication to validate
18 the pharmacy records in accordance with State and federal
19 law;

20 (6) limit the number of prescriptions audited to no
21 more than 100 prescriptions per audit and an entity shall
22 not audit more than 200 prescriptions in any 12-month
23 period, except in cases of fraud or knowing and willful
24 misrepresentation; a refill shall not constitute a
25 separate prescription and a pharmacy shall not be audited
26 more than once every 6 months;

1 (7) provide the pharmacy or its contracting agent with
2 a copy of the preliminary audit report within 45 days
3 after the conclusion of the audit;

4 (8) be allowed to conduct a follow-up audit on site if
5 a remote or desk audit reveals the necessity for a review
6 of additional claims;

7 (9) accept invoice audits as validation invoices from
8 any wholesaler registered with the Department of Financial
9 and Professional Regulation from which the pharmacy has
10 purchased prescription drugs or, in the case of durable
11 medical equipment or sickroom supplies, invoices from an
12 authorized distributor other than a wholesaler;

13 (10) provide the pharmacy or its contracting agent
14 with the ability to provide documentation to address a
15 discrepancy or audit finding if the documentation is
16 received by the pharmacy benefit manager no later than the
17 45th day after the preliminary audit report was provided
18 to the pharmacy or its contracting agent; the pharmacy
19 benefit manager shall consider a reasonable request from
20 the pharmacy for an extension of time to submit
21 documentation to address or correct any findings in the
22 report;

23 (11) be required to provide the pharmacy or its
24 contracting agent with the final audit report no later
25 than 90 days after the initial audit report was provided
26 to the pharmacy or its contracting agent;

1 (12) conduct the audit in consultation with a
2 pharmacist in specific cases if the audit involves
3 clinical or professional judgment;

4 (13) not chargeback, recoup, or collect penalties from
5 a pharmacy until the time period to file an appeal of the
6 final pharmacy audit report has passed or the appeals
7 process has been exhausted, whichever is later, unless the
8 identified discrepancy is expected to exceed \$25,000, in
9 which case the auditing entity may withhold future
10 payments in excess of that amount until the final
11 resolution of the audit;

12 (14) not compensate the employee or contractor
13 conducting the audit based on a percentage of the amount
14 claimed or recouped pursuant to the audit;

15 (15) not use extrapolation to calculate penalties or
16 amounts to be charged back or recouped unless otherwise
17 required by federal law or regulation; any amount to be
18 charged back or recouped due to overpayment may not exceed
19 the amount the pharmacy was overpaid;

20 (16) not include dispensing fees in the calculation of
21 overpayments unless a prescription is considered a
22 misfill, the medication is not delivered to the patient,
23 the prescription is not valid, or the prescriber denies
24 authorizing the prescription; and

25 (17) conduct a pharmacy audit under the same standards
26 and parameters as conducted for other similarly situated

1 pharmacies audited by the auditing entity.

2 (c) Except as otherwise provided by State or federal law,
3 an auditing entity conducting a pharmacy audit may have access
4 to a pharmacy's previous audit report only if the report was
5 prepared by that auditing entity.

6 (d) Information collected during a pharmacy audit shall be
7 confidential by law, except that the auditing entity
8 conducting the pharmacy audit may share the information with
9 the health benefit plan for which a pharmacy audit is being
10 conducted and with any regulatory agencies and law enforcement
11 agencies as required by law.

12 (e) A pharmacy may not be subject to a chargeback or
13 recoupment for a clerical or recordkeeping error in a required
14 document or record, including a typographical error or
15 computer error, unless the pharmacy benefit manager can
16 provide proof of intent to commit fraud or such error results
17 in actual financial harm to the pharmacy benefit manager, a
18 health plan managed by the pharmacy benefit manager, or a
19 consumer.

20 (f) A pharmacy shall have the right to file a written
21 appeal of a preliminary and final pharmacy audit report in
22 accordance with the procedures established by the entity
23 conducting the pharmacy audit.

24 (g) No interest shall accrue for any party during the
25 audit period, beginning with the notice of the pharmacy audit
26 and ending with the conclusion of the appeals process.

1 (h) An auditing entity must provide a copy to the plan
2 sponsor of its claims that were included in the audit, and any
3 recouped money shall be returned to the plan sponsor, unless
4 otherwise contractually agreed upon by the plan sponsor and
5 the pharmacy benefit manager.

6 (i) The parameters of an audit must comply with
7 manufacturer listings or recommendations, unless otherwise
8 prescribed by the treating provider, and must be covered under
9 the individual's health plan, for the following:

10 (1) the day supply for eye drops must be calculated so
11 that the consumer pays only one 30-day copayment if the
12 bottle of eye drops is intended by the manufacturer to be a
13 30-day supply;

14 (2) the day supply for insulin must be calculated so
15 that the highest dose prescribed is used to determine the
16 day supply and consumer copayment; and

17 (3) the day supply for topical product must be
18 determined by the judgment of the pharmacist or treating
19 provider upon the treated area.

20 (j) This Section shall not apply to:

21 (1) audits in which suspected fraud or knowing and
22 willful misrepresentation is evidenced by a physical
23 review, review of claims data or statements, or other
24 investigative methods;

25 (2) audits of claims paid for by federally funded
26 programs not applicable to health insurance coverage

1 regulated by the Department; or
2 (3) concurrent reviews or desk audits that occur
3 within 3 business days after transmission of a claim and
4 in which no chargeback or recoupment is demanded.

5 ARTICLE 115.

6 Section 115-5. The Illinois Public Aid Code is amended by
7 changing Section 5-30.11 as follows:

8 (305 ILCS 5/5-30.11)

9 Sec. 5-30.11. Treatment of autism spectrum disorder.
10 Treatment of autism spectrum disorder through applied behavior
11 analysis shall be covered under the medical assistance program
12 under this Article for children with a diagnosis of autism
13 spectrum disorder when (1) ordered by: ~~(1)~~ a physician
14 licensed to practice medicine in all its branches or a
15 psychologist licensed by the Department of Financial and
16 Professional Regulation and (2) ~~and rendered by a licensed or~~
17 ~~certified health care professional with expertise in applied~~
18 ~~behavior analysis; or (2) when evaluated and treated by a~~
19 behavior analyst as recognized by the Department or licensed
20 by the Department of Financial and Professional Regulation to
21 practice applied behavior analysis in this State. Such
22 coverage may be limited to age ranges based on evidence-based
23 best practices. Appropriate State plan amendments as well as

1 rules regarding provision of services and providers will be
2 submitted by September 1, 2019. Pursuant to the flexibilities
3 allowed by the federal Centers for Medicare and Medicaid
4 Services to Illinois under the Medical Assistance Program, the
5 Department shall enroll and reimburse qualified staff to
6 perform applied behavior analysis services in advance of
7 Illinois licensure activities performed by the Department of
8 Financial and Professional Regulation. These services shall be
9 covered if they are provided in a home or community setting or
10 in an office-based setting. The Department may conduct annual
11 on-site reviews of the services authorized under this Section.
12 Provider enrollment shall occur no later than September 1,
13 2023.

14 (Source: P.A. 101-10, eff. 6-5-19; 102-558, eff. 8-20-21;
15 102-953, eff. 5-27-22.)

16 ARTICLE 120.

17 Section 120-5. The Illinois Public Aid Code is amended by
18 adding Section 5-5a.1 as follows:

19 (305 ILCS 5/5-5a.1 new)

20 Sec. 5-5a.1. Telehealth services for persons with
21 intellectual and developmental disabilities. The Department
22 shall file an amendment to the Home and Community-Based
23 Services Waiver Program for Adults with Developmental

1 Disabilities authorized under Section 1915(c) of the Social
2 Security Act to incorporate telehealth services administered
3 by a provider of telehealth services that demonstrates
4 knowledge and experience in providing medical and emergency
5 services for persons with intellectual and developmental
6 disabilities. The Department shall pay administrative fees
7 associated with implementing telehealth services for all
8 persons with intellectual and developmental disabilities who
9 are receiving services under the Home and Community-Based
10 Services Waiver Program for Adults with Developmental
11 Disabilities.

12 ARTICLE 125.

13 Section 125-5. The Illinois Public Aid Code is amended by
14 adding Section 5-48 as follows:

15 (305 ILCS 5/5-48 new)

16 Sec. 5-48. Increasing behavioral health service capacity
17 in federally qualified health centers. The Department of
18 Healthcare and Family Services shall develop policies and
19 procedures with the goal of increasing the capacity of
20 behavioral health services provided by federally qualified
21 health centers as defined in Section 1905(1)(2)(B) of the
22 federal Social Security Act. Subject to federal approval, the
23 Department shall develop, no later than January 1, 2024,

1 billing policies that provide reimbursement to federally
2 qualified health centers for services rendered by
3 graduate-level, sub-clinical behavioral health professionals
4 who deliver care under the supervision of a fully licensed
5 behavioral health clinician who is licensed as a clinical
6 social worker, clinical professional counselor, marriage and
7 family therapist, or clinical psychologist.

8 To be eligible for reimbursement as provided for in this
9 Section, a graduate-level, sub-clinical professional must meet
10 the educational requirements set forth by the Department of
11 Financial and Professional Regulation for licensed clinical
12 social workers, licensed clinical professional counselors,
13 licensed marriage and family therapists, or licensed clinical
14 psychologists. An individual seeking to fulfill post-degree
15 experience requirements in order to qualify for licensing as a
16 clinical social worker, clinical professional counselor,
17 marriage and family therapist, or clinical psychologist shall
18 also be eligible for reimbursement under this Section so long
19 as the individual is in compliance with all applicable laws
20 and regulations regarding supervision, including, but not
21 limited to, the requirement that the supervised experience be
22 under the order, control, and full professional responsibility
23 of the individual's supervisor or that the individual is
24 designated by a title that clearly indicates training status.

25 The Department shall work with a trade association
26 representing a majority of federally qualified health centers

1 operating in Illinois to develop the policies and procedures
2 required under this Section.

3 ARTICLE 130.

4 Section 130-5. The Illinois Insurance Code is amended by
5 changing Section 363 as follows:

6 (215 ILCS 5/363) (from Ch. 73, par. 975)

7 Sec. 363. Medicare supplement policies; minimum standards.

8 (1) Except as otherwise specifically provided therein,
9 this Section and Section 363a of this Code shall apply to:

10 (a) all Medicare supplement policies and subscriber
11 contracts delivered or issued for delivery in this State
12 on and after January 1, 1989; and

13 (b) all certificates issued under group Medicare
14 supplement policies or subscriber contracts, which
15 certificates are issued or issued for delivery in this
16 State on and after January 1, 1989.

17 This Section shall not apply to "Accident Only" or
18 "Specified Disease" types of policies. The provisions of this
19 Section are not intended to prohibit or apply to policies or
20 health care benefit plans, including group conversion
21 policies, provided to Medicare eligible persons, which
22 policies or plans are not marketed or purported or held to be
23 Medicare supplement policies or benefit plans.

1 (2) For the purposes of this Section and Section 363a, the
2 following terms have the following meanings:

3 (a) "Applicant" means:

4 (i) in the case of individual Medicare supplement
5 policy, the person who seeks to contract for insurance
6 benefits, and

7 (ii) in the case of a group Medicare policy or
8 subscriber contract, the proposed certificate holder.

9 (b) "Certificate" means any certificate delivered or
10 issued for delivery in this State under a group Medicare
11 supplement policy.

12 (c) "Medicare supplement policy" means an individual
13 policy of accident and health insurance, as defined in
14 paragraph (a) of subsection (2) of Section 355a of this
15 Code, or a group policy or certificate delivered or issued
16 for delivery in this State by an insurer, fraternal
17 benefit society, voluntary health service plan, or health
18 maintenance organization, other than a policy issued
19 pursuant to a contract under Section 1876 of the federal
20 Social Security Act (42 U.S.C. Section 1395 et seq.) or a
21 policy issued under a demonstration project specified in
22 42 U.S.C. Section 1395ss(g)(1), or any similar
23 organization, that is advertised, marketed, or designed
24 primarily as a supplement to reimbursements under Medicare
25 for the hospital, medical, or surgical expenses of persons
26 eligible for Medicare.

1 (d) "Issuer" includes insurance companies, fraternal
2 benefit societies, voluntary health service plans, health
3 maintenance organizations, or any other entity providing
4 Medicare supplement insurance, unless the context clearly
5 indicates otherwise.

6 (e) "Medicare" means the Health Insurance for the Aged
7 Act, Title XVIII of the Social Security Amendments of
8 1965.

9 (3) No Medicare supplement insurance policy, contract, or
10 certificate, that provides benefits that duplicate benefits
11 provided by Medicare, shall be issued or issued for delivery
12 in this State after December 31, 1988. No such policy,
13 contract, or certificate shall provide lesser benefits than
14 those required under this Section or the existing Medicare
15 Supplement Minimum Standards Regulation, except where
16 duplication of Medicare benefits would result.

17 (4) Medicare supplement policies or certificates shall
18 have a notice prominently printed on the first page of the
19 policy or attached thereto stating in substance that the
20 policyholder or certificate holder shall have the right to
21 return the policy or certificate within 30 days of its
22 delivery and to have the premium refunded directly to him or
23 her in a timely manner if, after examination of the policy or
24 certificate, the insured person is not satisfied for any
25 reason.

26 (5) A Medicare supplement policy or certificate may not

1 deny a claim for losses incurred more than 6 months from the
2 effective date of coverage for a preexisting condition. The
3 policy may not define a preexisting condition more
4 restrictively than a condition for which medical advice was
5 given or treatment was recommended by or received from a
6 physician within 6 months before the effective date of
7 coverage.

8 (6) An issuer of a Medicare supplement policy shall:

9 (a) not deny coverage to an applicant under 65 years
10 of age who meets any of the following criteria:

11 (i) becomes eligible for Medicare by reason of
12 disability if the person makes application for a
13 Medicare supplement policy within 6 months of the
14 first day on which the person enrolls for benefits
15 under Medicare Part B; for a person who is
16 retroactively enrolled in Medicare Part B due to a
17 retroactive eligibility decision made by the Social
18 Security Administration, the application must be
19 submitted within a 6-month period beginning with the
20 month in which the person received notice of
21 retroactive eligibility to enroll;

22 (ii) has Medicare and an employer group health
23 plan (either primary or secondary to Medicare) that
24 terminates or ceases to provide all such supplemental
25 health benefits;

26 (iii) is insured by a Medicare Advantage plan that

1 includes a Health Maintenance Organization, a
2 Preferred Provider Organization, and a Private
3 Fee-For-Service or Medicare Select plan and the
4 applicant moves out of the plan's service area; the
5 insurer goes out of business, withdraws from the
6 market, or has its Medicare contract terminated; or
7 the plan violates its contract provisions or is
8 misrepresented in its marketing; or

9 (iv) is insured by a Medicare supplement policy
10 and the insurer goes out of business, withdraws from
11 the market, or the insurance company or agents
12 misrepresent the plan and the applicant is without
13 coverage;

14 (b) make available to persons eligible for Medicare by
15 reason of disability each type of Medicare supplement
16 policy the issuer makes available to persons eligible for
17 Medicare by reason of age;

18 (c) not charge individuals who become eligible for
19 Medicare by reason of disability and who are under the age
20 of 65 premium rates for any medical supplemental insurance
21 benefit plan offered by the issuer that exceed the
22 issuer's highest rate on the current rate schedule filed
23 with the Division of Insurance for that plan to
24 individuals who are age 65 or older; and

25 (d) provide the rights granted by items (a) through
26 (d), for 6 months after the effective date of this

1 amendatory Act of the 95th General Assembly, to any person
2 who had enrolled for benefits under Medicare Part B prior
3 to this amendatory Act of the 95th General Assembly who
4 otherwise would have been eligible for coverage under item
5 (a).

6 (7) The Director shall issue reasonable rules and
7 regulations for the following purposes:

8 (a) To establish specific standards for policy
9 provisions of Medicare policies and certificates. The
10 standards shall be in accordance with the requirements of
11 this Code. No requirement of this Code relating to minimum
12 required policy benefits, other than the minimum standards
13 contained in this Section and Section 363a, shall apply to
14 Medicare supplement policies and certificates. The
15 standards may cover, but are not limited to the following:

16 (A) Terms of renewability.

17 (B) Initial and subsequent terms of eligibility.

18 (C) Non-duplication of coverage.

19 (D) Probationary and elimination periods.

20 (E) Benefit limitations, exceptions and
21 reductions.

22 (F) Requirements for replacement.

23 (G) Recurrent conditions.

24 (H) Definition of terms.

25 (I) Requirements for issuing rebates or credits to
26 policyholders if the policy's loss ratio does not

1 comply with subsection (7) of Section 363a.

2 (J) Uniform methodology for the calculating and
3 reporting of loss ratio information.

4 (K) Assuring public access to loss ratio
5 information of an issuer of Medicare supplement
6 insurance.

7 (L) Establishing a process for approving or
8 disapproving proposed premium increases.

9 (M) Establishing a policy for holding public
10 hearings prior to approval of premium increases.

11 (N) Establishing standards for Medicare Select
12 policies.

13 (O) Prohibited policy provisions not otherwise
14 specifically authorized by statute that, in the
15 opinion of the Director, are unjust, unfair, or
16 unfairly discriminatory to any person insured or
17 proposed for coverage under a medicare supplement
18 policy or certificate.

19 (b) To establish minimum standards for benefits and
20 claims payments, marketing practices, compensation
21 arrangements, and reporting practices for Medicare
22 supplement policies.

23 (c) To implement transitional requirements of Medicare
24 supplement insurance benefits and premiums of Medicare
25 supplement policies and certificates to conform to
26 Medicare program revisions.

1 (8) If an individual is at least 65 years of age but no
2 more than 75 years of age and has an existing Medicare
3 supplement policy, the individual is entitled to an annual
4 open enrollment period lasting 45 days, commencing with the
5 individual's birthday, and the individual may purchase any
6 Medicare supplement policy with the same issuer that offers
7 benefits equal to or lesser than those provided by the
8 previous coverage. During this open enrollment period, an
9 issuer of a Medicare supplement policy shall not deny or
10 condition the issuance or effectiveness of Medicare
11 supplemental coverage, nor discriminate in the pricing of
12 coverage, because of health status, claims experience, receipt
13 of health care, or a medical condition of the individual. An
14 issuer shall provide notice of this annual open enrollment
15 period for eligible Medicare supplement policyholders at the
16 time that the application is made for a Medicare supplement
17 policy or certificate. The notice shall be in a form that may
18 be prescribed by the Department.

19 (9) Without limiting an individual's eligibility under
20 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A), for
21 at least 63 days after the later of the applicant's loss of
22 benefits or the notice of termination of benefits, including a
23 notice of claim denial due to termination of benefits, under
24 the State's medical assistance program under Article V of the
25 Illinois Public Aid Code, an issuer shall not deny or
26 condition the issuance or effectiveness of any Medicare

1 supplement policy or certificate that is offered and is
2 available for issuance to new enrollees by the issuer; shall
3 not discriminate in the pricing of such a Medicare supplement
4 policy because of health status, claims experience, receipt of
5 health care, or medical condition; and shall not include a
6 policy provision that imposes an exclusion of benefits based
7 on a preexisting condition under such a Medicare supplement
8 policy if the individual:

9 (a) is enrolled for Medicare Part B;

10 (b) was enrolled in the State's medical assistance
11 program during the COVID-19 Public Health Emergency
12 described in Section 5-1.5 of the Illinois Public Aid
13 Code;

14 (c) was terminated or disenrolled from the State's
15 medical assistance program after the COVID-19 Public
16 Health Emergency and the later of the date of termination
17 of benefits or the date of the notice of termination,
18 including a notice of a claim denial due to termination,
19 occurred on, after, or no more than 63 days before the end
20 of either, as applicable:

21 (A) the individual's Medicare supplement open
22 enrollment period described in Department rules
23 implementing 42 U.S.C. 1395ss(s) (2) (A); or

24 (B) the 6-month period described in Section
25 363(6) (a) (i) of this Code; and

26 (d) submits evidence of the date of termination of

1 benefits or notice of termination under the State's
2 medical assistance program with the application for a
3 Medicare supplement policy or certificate.

4 (10) Each Medicare supplement policy and certificate
5 available from an insurer on and after the effective date of
6 this amendatory Act of the 103rd General Assembly shall be
7 made available to all applicants who qualify under
8 subparagraph (i) of paragraph (a) of subsection (6) or
9 Department rules implementing 42 U.S.C. 1395ss(s)(2)(A)
10 without regard to age or applicability of a Medicare Part B
11 late enrollment penalty.

12 (Source: P.A. 102-142, eff. 1-1-22.)

13 ARTICLE 135.

14 Section 135-5. The Illinois Public Aid Code is amended by
15 adding Section 5-49 as follows:

16 (305 ILCS 5/5-49 new)

17 Sec. 5-49. Long-acting reversible contraception. Subject
18 to federal approval, the Department shall adopt policies and
19 rates for long-acting reversible contraception by January 1,
20 2024 to ensure that reimbursement is not reduced by 4.4% below
21 list price. The Department shall submit any necessary
22 application to the federal Centers for Medicare and Medicaid
23 Services for the purposes of implementing such policies and

1 rates.

2 ARTICLE 140.

3 Section 140-5. The Illinois Public Aid Code is amended by
4 changing Section 5-30.8 as follows:

5 (305 ILCS 5/5-30.8)

6 Sec. 5-30.8. Managed care organization rate transparency.

7 (a) For the establishment of managed care organization
8 (MCO) capitation base rate payments from the State, including,
9 but not limited to: (i) hospital fee schedule reforms and
10 updates, (ii) rates related to a single State-mandated
11 preferred drug list, (iii) rate updates related to the State's
12 preferred drug list, (iv) inclusion of coverage for children
13 with special needs, (v) inclusion of coverage for children
14 within the child welfare system, (vi) annual MCO capitation
15 rates, and (vii) any retroactive provider fee schedule
16 adjustments or other changes required by legislation or other
17 actions, the Department of Healthcare and Family Services
18 shall implement a capitation base rate setting process
19 beginning on July 27, 2018 (the effective date of Public Act
20 100-646) which shall include all of the following elements of
21 transparency:

22 (1) The Department shall include participating MCOs
23 and a statewide trade association representing a majority

1 of participating MCOs in meetings to discuss the impact to
2 base capitation rates as a result of any new or updated
3 hospital fee schedules or other provider fee schedules.
4 Additionally, the Department shall share any data or
5 reports used to develop MCO capitation rates with
6 participating MCOs. This data shall be comprehensive
7 enough for MCO actuaries to recreate and verify the
8 accuracy of the capitation base rate build-up.

9 (2) The Department shall not limit the number of
10 experts that each MCO is allowed to bring to the draft
11 capitation base rate meeting or the final capitation base
12 rate review meeting. Draft and final capitation base rate
13 review meetings shall be held in at least 2 locations.

14 (3) The Department and its contracted actuary shall
15 meet with all participating MCOs simultaneously and
16 together along with consulting actuaries contracted with
17 statewide trade association representing a majority of
18 Medicaid health plans at the request of the plans.
19 Participating MCOs shall additionally, at their request,
20 be granted individual capitation rate development meetings
21 with the Department.

22 (4) (Blank). ~~Any quality incentive or other incentive~~
23 ~~withholding of any portion of the actuarially certified~~
24 ~~capitation rates must be budget neutral. The entirety of~~
25 ~~any aggregate withheld amounts must be returned to the~~
26 ~~MCOs in proportion to their performance on the relevant~~

1 ~~performance metric. No amounts shall be returned to the~~
2 ~~Department if all performance measures are not achieved to~~
3 ~~the extent allowable by federal law and regulations.~~

4 (4.5) Effective for calendar year 2024, a quality
5 withhold program may be established by the Department for
6 the HealthChoice Illinois Managed Care Program or any
7 successor program. If such program withholds a portion of
8 the actuarially certified capitation rates, the program
9 must meet the following criteria: (i) benchmarks must be
10 discussed publicly, based on predetermined quality
11 standards that align with the Department's federally
12 approved quality strategy, and set by publication on the
13 Department's website at least 4 months prior to the start
14 of the calendar year; (ii) incentive measures and
15 benchmarks must be reasonable and attainable within the
16 measurement year; and (iii) no less than 75% of the
17 metrics shall be tied to nationally recognized measures.
18 Any non-nationally recognized measures shall be in the
19 reporting category for at least 2 years of experience and
20 evaluation for consistency among MCOs prior to setting a
21 performance baseline. The Department shall provide MCOs
22 with biannual industry average data on the quality
23 withhold measures. If all the money withheld is not earned
24 back by individual MCOs, the Department shall reallocate
25 unearned funds among the MCOs in one or both of the
26 following manners: based upon their quality performance or

1 for quality and equity improvement projects. Nothing in
2 this paragraph prohibits the Department and the MCOs from
3 establishing any other quality performance program.

4 (5) Upon request, the Department shall provide written
5 responses to questions regarding MCO capitation base
6 rates, the capitation base development methodology, and
7 MCO capitation rate data, and all other requests regarding
8 capitation rates from MCOs. Upon request, the Department
9 shall also provide to the MCOs materials used in
10 incorporating provider fee schedules into base capitation
11 rates.

12 (b) For the development of capitation base rates for new
13 capitation rate years:

14 (1) The Department shall take into account emerging
15 experience in the development of the annual MCO capitation
16 base rates, including, but not limited to, current-year
17 cost and utilization trends observed by MCOs in an
18 actuarially sound manner and in accordance with federal
19 law and regulations.

20 (2) No later than January 1 of each year, the
21 Department shall release an agreed upon annual calendar
22 that outlines dates for capitation rate setting meetings
23 for that year. The calendar shall include at least the
24 following meetings and deadlines:

25 (A) An initial meeting for the Department to
26 review MCO data and draft rate assumptions to be used

1 in the development of capitation base rates for the
2 following year.

3 (B) A draft rate meeting after the Department
4 provides the MCOs with the draft capitation base rates
5 to discuss, review, and seek feedback regarding the
6 draft capitation base rates.

7 (3) Prior to the submission of final capitation rates
8 to the federal Centers for Medicare and Medicaid Services,
9 the Department shall provide the MCOs with a final
10 actuarial report including the final capitation base rates
11 for the following year and subsequently conduct a final
12 capitation base review meeting. Final capitation rates
13 shall be marked final.

14 (c) For the development of capitation base rates
15 reflecting policy changes:

16 (1) Unless contrary to federal law and regulation, the
17 Department must provide notice to MCOs of any significant
18 operational policy change no later than 60 days prior to
19 the effective date of an operational policy change in
20 order to give MCOs time to prepare for and implement the
21 operational policy change and to ensure that the quality
22 and delivery of enrollee health care is not disrupted.
23 "Operational policy change" means a change to operational
24 requirements such as reporting formats, encounter
25 submission definitional changes, or required provider
26 interfaces made at the sole discretion of the Department

1 and not required by legislation with a retroactive
2 effective date. Nothing in this Section shall be construed
3 as a requirement to delay or prohibit implementation of
4 policy changes that impact enrollee benefits as determined
5 in the sole discretion of the Department.

6 (2) No later than 60 days after the effective date of
7 the policy change or program implementation, the
8 Department shall meet with the MCOs regarding the initial
9 data collection needed to establish capitation base rates
10 for the policy change. Additionally, the Department shall
11 share with the participating MCOs what other data is
12 needed to estimate the change and the processes for
13 collection of that data that shall be utilized to develop
14 capitation base rates.

15 (3) No later than 60 days after the effective date of
16 the policy change or program implementation, the
17 Department shall meet with MCOs to review data and the
18 Department's written draft assumptions to be used in
19 development of capitation base rates for the policy
20 change, and shall provide opportunities for questions to
21 be asked and answered.

22 (4) No later than 60 days after the effective date of
23 the policy change or program implementation, the
24 Department shall provide the MCOs with draft capitation
25 base rates and shall also conduct a draft capitation base
26 rate meeting with MCOs to discuss, review, and seek

1 feedback regarding the draft capitation base rates.

2 (d) For the development of capitation base rates for
3 retroactive policy or fee schedule changes:

4 (1) The Department shall meet with the MCOs regarding
5 the initial data collection needed to establish capitation
6 base rates for the policy change. Additionally, the
7 Department shall share with the participating MCOs what
8 other data is needed to estimate the change and the
9 processes for collection of the data that shall be
10 utilized to develop capitation base rates.

11 (2) The Department shall meet with MCOs to review data
12 and the Department's written draft assumptions to be used
13 in development of capitation base rates for the policy
14 change. The Department shall provide opportunities for
15 questions to be asked and answered.

16 (3) The Department shall provide the MCOs with draft
17 capitation rates and shall also conduct a draft rate
18 meeting with MCOs to discuss, review, and seek feedback
19 regarding the draft capitation base rates.

20 (4) The Department shall inform MCOs no less than
21 quarterly of upcoming benefit and policy changes to the
22 Medicaid program.

23 (e) Meetings of the group established to discuss Medicaid
24 capitation rates under this Section shall be closed to the
25 public and shall not be subject to the Open Meetings Act.
26 Records and information produced by the group established to

1 discuss Medicaid capitation rates under this Section shall be
2 confidential and not subject to the Freedom of Information
3 Act.

4 (Source: P.A. 100-646, eff. 7-27-18; 101-81, eff. 7-12-19.)

5 ARTICLE 145.

6 Section 145-5. The Medical Practice Act of 1987 is amended
7 by changing Section 54.2 and by adding Section 15.5 as
8 follows:

9 (225 ILCS 60/15.5 new)

10 Sec. 15.5. International medical graduate physicians;
11 licensure. After January 1, 2025, an international medical
12 graduate physician may apply to the Department for a limited
13 license. The Department shall adopt rules establishing
14 qualifications and application fees for the limited licensure
15 of international medical graduate physicians and may adopt
16 other rules as may be necessary for the implementation of this
17 Section. The Department shall adopt rules that provide a
18 pathway to full licensure for limited license holders after
19 the licensee successfully completes a supervision period and
20 satisfies other qualifications as established by the
21 Department.

22 (225 ILCS 60/54.2)

1 (Section scheduled to be repealed on January 1, 2027)

2 Sec. 54.2. Physician delegation of authority.

3 (a) Nothing in this Act shall be construed to limit the
4 delegation of patient care tasks or duties by a physician, to a
5 licensed practical nurse, a registered professional nurse, or
6 other licensed person practicing within the scope of his or
7 her individual licensing Act. Delegation by a physician
8 licensed to practice medicine in all its branches to physician
9 assistants or advanced practice registered nurses is also
10 addressed in Section 54.5 of this Act. No physician may
11 delegate any patient care task or duty that is statutorily or
12 by rule mandated to be performed by a physician.

13 (b) In an office or practice setting and within a
14 physician-patient relationship, a physician may delegate
15 patient care tasks or duties to an unlicensed person who
16 possesses appropriate training and experience provided a
17 health care professional, who is practicing within the scope
18 of such licensed professional's individual licensing Act, is
19 on site to provide assistance.

20 (c) Any such patient care task or duty delegated to a
21 licensed or unlicensed person must be within the scope of
22 practice, education, training, or experience of the delegating
23 physician and within the context of a physician-patient
24 relationship.

25 (d) Nothing in this Section shall be construed to affect
26 referrals for professional services required by law.

1 (e) The Department shall have the authority to promulgate
2 rules concerning a physician's delegation, including but not
3 limited to, the use of light emitting devices for patient care
4 or treatment.

5 (f) Nothing in this Act shall be construed to limit the
6 method of delegation that may be authorized by any means,
7 including, but not limited to, oral, written, electronic,
8 standing orders, protocols, guidelines, or verbal orders.

9 (g) A physician licensed to practice medicine in all of
10 its branches under this Act may delegate any and all authority
11 prescribed to him or her by law to international medical
12 graduate physicians, so long as the tasks or duties are within
13 the scope of practice, education, training, or experience of
14 the delegating physician who is on site to provide assistance.
15 An international medical graduate working in Illinois pursuant
16 to this subsection is subject to all statutory and regulatory
17 requirements of this Act, as applicable, relating to the
18 standards of care. An international medical graduate physician
19 is limited to providing treatment under the supervision of a
20 physician licensed to practice medicine in all of its
21 branches. The supervising physician or employer must keep
22 record of and make available upon request by the Department
23 the following: (1) evidence of education certified by the
24 Educational Commission for Foreign Medical Graduates; (2)
25 evidence of passage of Step 1, Step 2 Clinical Knowledge, and
26 Step 3 of the United States Medical Licensing Examination as

1 required by this Act; and (3) evidence of an unencumbered
2 license from another country. This subsection does not apply
3 to any international medical graduate whose license as a
4 physician is revoked, suspended, or otherwise encumbered. This
5 subsection is inoperative upon the adoption of rules
6 implementing Section 15.5.

7 (Source: P.A. 103-1, eff. 4-27-23.)

8 ARTICLE 150.

9 Section 150-5. The Illinois Administrative Procedure Act
10 is amended by adding Section 5-45.37 as follows:

11 (5 ILCS 100/5-45.37 new)

12 Sec. 5-45.37. Emergency rulemaking; medical services for
13 certain noncitizens. To provide for the expeditious and
14 effective ongoing implementation of Section 12-4.35 of the
15 Illinois Public Aid Code, emergency rules implementing Section
16 12-4.35 of the Illinois Public Aid Code may be adopted in
17 accordance with Section 5-45 by the Department of Healthcare
18 and Family Services, except that the limitation on the number
19 of emergency rules that may be adopted in a 24-month period
20 shall not apply. The adoption of emergency rules authorized by
21 Section 5-45 and this Section is deemed to be necessary for the
22 public interest, safety, and welfare.

23 This Section is repealed 2 years after the effective date

1 of this amendatory Act of the 103rd General Assembly.

2 Section 150-10. The Illinois Public Aid Code is amended by
3 changing Section 12-4.35 as follows:

4 (305 ILCS 5/12-4.35)

5 Sec. 12-4.35. Medical services for certain noncitizens.

6 (a) Notwithstanding Section 1-11 of this Code or Section
7 20(a) of the Children's Health Insurance Program Act, the
8 Department of Healthcare and Family Services may provide
9 medical services to noncitizens who have not yet attained 19
10 years of age and who are not eligible for medical assistance
11 under Article V of this Code or under the Children's Health
12 Insurance Program created by the Children's Health Insurance
13 Program Act due to their not meeting the otherwise applicable
14 provisions of Section 1-11 of this Code or Section 20(a) of the
15 Children's Health Insurance Program Act. The medical services
16 available, standards for eligibility, and other conditions of
17 participation under this Section shall be established by rule
18 by the Department; however, any such rule shall be at least as
19 restrictive as the rules for medical assistance under Article
20 V of this Code or the Children's Health Insurance Program
21 created by the Children's Health Insurance Program Act.

22 (a-5) Notwithstanding Section 1-11 of this Code, the
23 Department of Healthcare and Family Services may provide
24 medical assistance in accordance with Article V of this Code

1 to noncitizens over the age of 65 years of age who are not
2 eligible for medical assistance under Article V of this Code
3 due to their not meeting the otherwise applicable provisions
4 of Section 1-11 of this Code, whose income is at or below 100%
5 of the federal poverty level after deducting the costs of
6 medical or other remedial care, and who would otherwise meet
7 the eligibility requirements in Section 5-2 of this Code. The
8 medical services available, standards for eligibility, and
9 other conditions of participation under this Section shall be
10 established by rule by the Department; however, any such rule
11 shall be at least as restrictive as the rules for medical
12 assistance under Article V of this Code.

13 (a-6) By May 30, 2022, notwithstanding Section 1-11 of
14 this Code, the Department of Healthcare and Family Services
15 may provide medical services to noncitizens 55 years of age
16 through 64 years of age who (i) are not eligible for medical
17 assistance under Article V of this Code due to their not
18 meeting the otherwise applicable provisions of Section 1-11 of
19 this Code and (ii) have income at or below 133% of the federal
20 poverty level plus 5% for the applicable family size as
21 determined under applicable federal law and regulations.
22 Persons eligible for medical services under Public Act 102-16
23 shall receive benefits identical to the benefits provided
24 under the Health Benefits Service Package as that term is
25 defined in subsection (m) of Section 5-1.1 of this Code.

26 (a-7) By July 1, 2022, notwithstanding Section 1-11 of

1 this Code, the Department of Healthcare and Family Services
2 may provide medical services to noncitizens 42 years of age
3 through 54 years of age who (i) are not eligible for medical
4 assistance under Article V of this Code due to their not
5 meeting the otherwise applicable provisions of Section 1-11 of
6 this Code and (ii) have income at or below 133% of the federal
7 poverty level plus 5% for the applicable family size as
8 determined under applicable federal law and regulations. The
9 medical services available, standards for eligibility, and
10 other conditions of participation under this Section shall be
11 established by rule by the Department; however, any such rule
12 shall be at least as restrictive as the rules for medical
13 assistance under Article V of this Code. In order to provide
14 for the timely and expeditious implementation of this
15 subsection, the Department may adopt rules necessary to
16 establish and implement this subsection through the use of
17 emergency rulemaking in accordance with Section 5-45 of the
18 Illinois Administrative Procedure Act. For purposes of the
19 Illinois Administrative Procedure Act, the General Assembly
20 finds that the adoption of rules to implement this subsection
21 is deemed necessary for the public interest, safety, and
22 welfare.

23 (a-10) Notwithstanding the provisions of Section 1-11, the
24 Department shall cover immunosuppressive drugs and related
25 services associated with post-kidney transplant management,
26 excluding long-term care costs, for noncitizens who: (i) are

1 not eligible for comprehensive medical benefits; (ii) meet the
2 residency requirements of Section 5-3; and (iii) would meet
3 the financial eligibility requirements of Section 5-2.

4 (b) The Department is authorized to take any action that
5 would not otherwise be prohibited by applicable law,
6 including, without limitation, cessation or limitation of
7 enrollment, reduction of available medical services, and
8 changing standards for eligibility, that is deemed necessary
9 by the Department during a State fiscal year to assure that
10 payments under this Section do not exceed available funds.

11 (c) (Blank).

12 (d) (Blank).

13 (e) In order to provide for the expeditious and effective
14 ongoing implementation of this Section, the Department may
15 adopt rules through the use of emergency rulemaking in
16 accordance with Section 5-45 of the Illinois Administrative
17 Procedure Act, except that the limitation on the number of
18 emergency rules that may be adopted in a 24-month period shall
19 not apply. For purposes of the Illinois Administrative
20 Procedure Act, the General Assembly finds that the adoption of
21 rules to implement this Section is deemed necessary for the
22 public interest, safety, and welfare. This subsection (e) is
23 inoperative on and after July 1, 2025.

24 (Source: P.A. 101-636, eff. 6-10-20; 102-16, eff. 6-17-21;
25 102-43, Article 25, Section 25-15, eff. 7-6-21; 102-43,
26 Article 45, Section 45-5, eff. 7-6-21; 102-813, eff. 5-13-22;

1 102-1037, eff. 6-2-22.)

2 ARTICLE 999.

3 Section 999-99. Effective date. This Article and Articles
4 1, 5, 10, 130, 145, and 150 take effect upon becoming law and
5 Articles 65, 115, 120, and 135 take effect July 1, 2023."