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1 AMENDMENT TO SENATE BILL 3268

2 AMENDMENT NO. _____. Amend Senate Bill 3268, AS AMENDED,
3 by replacing everything after the enacting clause with the
4 following:

5 "ARTICLE 5.

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

8 (305 ILCS 5/5-5)

9 Sec. 5-5. Medical services. The Illinois Department, by
10 rule, shall determine the quantity and quality of and the rate
11 of reimbursement for the medical assistance for which payment
12 will be authorized, and the medical services to be provided,
13 which may include all or part of the following: (1) inpatient
14 hospital services; (2) outpatient hospital services; (3) other
15 laboratory and X-ray services; (4) skilled nursing home

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

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

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

25 Notwithstanding any other provision of this Code,
26 reproductive health care that is otherwise legal in Illinois

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

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

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

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

26 On and after July 1, 2012, the Department of Healthcare

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

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

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

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

22 On and after July 1, 2018, targeted dental services, as
23 set forth in Exhibit D of the Consent Decree entered by the
24 United States District Court for the Northern District of
25 Illinois, Eastern Division, in the matter of Memisovski v.
26 Maram, Case No. 92 C 1982, that are provided to adults under

1 the medical assistance program shall be established at no less
2 than the rates set forth in the "New Rate" column in Exhibit D
3 of the Consent Decree for targeted dental services that are
4 provided to persons under the age of 18 under the medical
5 assistance program.

6 Subject to federal approval, on and after January 1, 2025,
7 the rates paid for sedation evaluation and the provision of
8 deep sedation and intravenous sedation for the purpose of
9 dental services shall be increased by 33% above the rates in
10 effect on December 31, 2024. The rates paid for nitrous oxide
11 sedation shall not be impacted by this paragraph and shall
12 remain the same as the rates in effect on December 31, 2024.

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

26 On and after January 1, 2022, the Department of Healthcare

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

22 The Illinois Department, by rule, may distinguish and
23 classify the medical services to be provided only in
24 accordance with the classes of persons designated in Section
25 5-2.

26 The Department of Healthcare and Family Services must

1 provide coverage and reimbursement for amino acid-based
2 elemental formulas, regardless of delivery method, for the
3 diagnosis and treatment of (i) eosinophilic disorders and (ii)
4 short bowel syndrome when the prescribing physician has issued
5 a written order stating that the amino acid-based elemental
6 formula is medically necessary.

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

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

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

16 (C) A mammogram at the age and intervals considered
17 medically necessary by the individual's health care
18 provider for individuals under 40 years of age and having
19 a family history of breast cancer, prior personal history
20 of breast cancer, positive genetic testing, or other risk
21 factors.

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

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

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

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

16 All screenings shall include a physical breast exam,
17 instruction on self-examination and information regarding the
18 frequency of self-examination and its value as a preventative
19 tool.

20 For purposes of this Section:

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

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

1 breast.

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

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

13 If, at any time, the Secretary of the United States
14 Department of Health and Human Services, or its successor
15 agency, promulgates rules or regulations to be published in
16 the Federal Register or publishes a comment in the Federal
17 Register or issues an opinion, guidance, or other action that
18 would require the State, pursuant to any provision of the
19 Patient Protection and Affordable Care Act (Public Law
20 111-148), including, but not limited to, 42 U.S.C.
21 18031(d)(3)(B) or any successor provision, to defray the cost
22 of any coverage for breast tomosynthesis outlined in this
23 paragraph, then the requirement that an insurer cover breast
24 tomosynthesis is inoperative other than any such coverage
25 authorized under Section 1902 of the Social Security Act, 42
26 U.S.C. 1396a, and the State shall not assume any obligation

1 for the cost of coverage for breast tomosynthesis set forth in
2 this paragraph.

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

8 On and after January 1, 2012, providers participating in a
9 quality improvement program approved by the Department shall
10 be reimbursed for screening and diagnostic mammography at the
11 same rate as the Medicare program's rates, including the
12 increased reimbursement for digital mammography and, after
13 January 1, 2023 (the effective date of Public Act 102-1018),
14 breast tomosynthesis.

15 The Department shall convene an expert panel including
16 representatives of hospitals, free-standing mammography
17 facilities, and doctors, including radiologists, to establish
18 quality standards for mammography.

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

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

1 treatment centers, breast cancer quality organizations, and
2 doctors, including breast surgeons, reconstructive breast
3 surgeons, oncologists, and primary care providers to establish
4 quality standards for breast cancer treatment.

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

12 The Department shall establish a methodology to remind
13 individuals who are age-appropriate for screening mammography,
14 but who have not received a mammogram within the previous 18
15 months, of the importance and benefit of screening
16 mammography. The Department shall work with experts in breast
17 cancer outreach and patient navigation to optimize these
18 reminders and shall establish a methodology for evaluating
19 their effectiveness and modifying the methodology based on the
20 evaluation.

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

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

15 The Department shall require all networks of care to
16 develop a means either internally or by contract with experts
17 in navigation and community outreach to navigate cancer
18 patients to comprehensive care in a timely fashion. The
19 Department shall require all networks of care to include
20 access for patients diagnosed with cancer to at least one
21 academic commission on cancer-accredited cancer program as an
22 in-network covered benefit.

23 The Department shall provide coverage and reimbursement
24 for a human papillomavirus (HPV) vaccine that is approved for
25 marketing by the federal Food and Drug Administration for all
26 persons between the ages of 9 and 45. Subject to federal

1 approval, the Department shall provide coverage and
2 reimbursement for a human papillomavirus (HPV) vaccine for
3 persons of the age of 46 and above who have been diagnosed with
4 cervical dysplasia with a high risk of recurrence or
5 progression. The Department shall disallow any
6 preauthorization requirements for the administration of the
7 human papillomavirus (HPV) vaccine.

8 On or after July 1, 2022, individuals who are otherwise
9 eligible for medical assistance under this Article shall
10 receive coverage for perinatal depression screenings for the
11 12-month period beginning on the last day of their pregnancy.
12 Medical assistance coverage under this paragraph shall be
13 conditioned on the use of a screening instrument approved by
14 the Department.

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

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

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

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

20 The Illinois Department shall establish such regulations
21 governing the dispensing of health services under this Article
22 as it shall deem appropriate. The Department should seek the
23 advice of formal professional advisory committees appointed by
24 the Director of the Illinois Department for the purpose of
25 providing regular advice on policy and administrative matters,
26 information dissemination and educational activities for

1 medical and health care providers, and consistency in
2 procedures to the Illinois Department.

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

13 The sponsor must negotiate formal written contracts with
14 medical providers for physician services, inpatient and
15 outpatient hospital care, home health services, treatment for
16 alcoholism and substance abuse, and other services determined
17 necessary by the Illinois Department by rule for delivery by
18 Partnerships. Physician services must include prenatal and
19 obstetrical care. The Illinois Department shall reimburse
20 medical services delivered by Partnership providers to clients
21 in target areas according to provisions of this Article and
22 the Illinois Health Finance Reform Act, except that:

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

1 such services.

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

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

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

18 Nothing in this Section shall limit the free choice of
19 practitioners, hospitals, and other providers of medical
20 services by clients. In order to ensure patient freedom of
21 choice, the Illinois Department shall immediately promulgate
22 all rules and take all other necessary actions so that
23 provided services may be accessed from therapeutically
24 certified optometrists to the full extent of the Illinois
25 Optometric Practice Act of 1987 without discriminating between
26 service providers.

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

4 The Illinois Department shall require health care
5 providers to maintain records that document the medical care
6 and services provided to recipients of Medical Assistance
7 under this Article. Such records must be retained for a period
8 of not less than 6 years from the date of service or as
9 provided by applicable State law, whichever period is longer,
10 except that if an audit is initiated within the required
11 retention period then the records must be retained until the
12 audit is completed and every exception is resolved. The
13 Illinois Department shall require health care providers to
14 make available, when authorized by the patient, in writing,
15 the medical records in a timely fashion to other health care
16 providers who are treating or serving persons eligible for
17 Medical Assistance under this Article. All dispensers of
18 medical services shall be required to maintain and retain
19 business and professional records sufficient to fully and
20 accurately document the nature, scope, details and receipt of
21 the health care provided to persons eligible for medical
22 assistance under this Code, in accordance with regulations
23 promulgated by the Illinois Department. The rules and
24 regulations shall require that proof of the receipt of
25 prescription drugs, dentures, prosthetic devices and
26 eyeglasses by eligible persons under this Section accompany

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

19 Notwithstanding any other law to the contrary, the
20 Illinois Department shall, within 365 days after July 22, 2013
21 (the effective date of Public Act 98-104), establish
22 procedures to permit skilled care facilities licensed under
23 the Nursing Home Care Act to submit monthly billing claims for
24 reimbursement purposes. Following development of these
25 procedures, the Department shall, by July 1, 2016, test the
26 viability of the new system and implement any necessary

1 operational or structural changes to its information
2 technology platforms in order to allow for the direct
3 acceptance and payment of nursing home claims.

4 Notwithstanding any other law to the contrary, the
5 Illinois Department shall, within 365 days after August 15,
6 2014 (the effective date of Public Act 98-963), establish
7 procedures to permit ID/DD facilities licensed under the ID/DD
8 Community Care Act and MC/DD facilities licensed under the
9 MC/DD Act to submit monthly billing claims for reimbursement
10 purposes. Following development of these procedures, the
11 Department shall have an additional 365 days to test the
12 viability of the new system and to ensure that any necessary
13 operational or structural changes to its information
14 technology platforms are implemented.

15 The Illinois Department shall require all dispensers of
16 medical services, other than an individual practitioner or
17 group of practitioners, desiring to participate in the Medical
18 Assistance program established under this Article to disclose
19 all financial, beneficial, ownership, equity, surety or other
20 interests in any and all firms, corporations, partnerships,
21 associations, business enterprises, joint ventures, agencies,
22 institutions or other legal entities providing any form of
23 health care services in this State under this Article.

24 The Illinois Department may require that all dispensers of
25 medical services desiring to participate in the medical
26 assistance program established under this Article disclose,

1 under such terms and conditions as the Illinois Department may
2 by rule establish, all inquiries from clients and attorneys
3 regarding medical bills paid by the Illinois Department, which
4 inquiries could indicate potential existence of claims or
5 liens for the Illinois Department.

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

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

18 Prior to enrollment and during the conditional enrollment
19 period in the medical assistance program, all vendors shall be
20 subject to enhanced oversight, screening, and review based on
21 the risk of fraud, waste, and abuse that is posed by the
22 category of risk of the vendor. The Illinois Department shall
23 establish the procedures for oversight, screening, and review,
24 which may include, but need not be limited to: criminal and
25 financial background checks; fingerprinting; license,
26 certification, and authorization verifications; unscheduled or

1 unannounced site visits; database checks; prepayment audit
2 reviews; audits; payment caps; payment suspensions; and other
3 screening as required by federal or State law.

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

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

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

26 (2) In the case of errors attributable to the Illinois

1 Department or any of its claims processing intermediaries
2 which result in an inability to receive, process, or
3 adjudicate a claim, the 180-day period shall not begin
4 until the provider has been notified of the error.

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

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

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

18 In the case of long term care facilities, within 120
19 calendar days of receipt by the facility of required
20 prescreening information, new admissions with associated
21 admission documents shall be submitted through the Medical
22 Electronic Data Interchange (MEDI) or the Recipient
23 Eligibility Verification (REV) System or shall be submitted
24 directly to the Department of Human Services using required
25 admission forms. Effective September 1, 2014, admission
26 documents, including all prescreening information, must be

1 submitted through MEDI or REV. Confirmation numbers assigned
2 to an accepted transaction shall be retained by a facility to
3 verify timely submittal. Once an admission transaction has
4 been completed, all resubmitted claims following prior
5 rejection are subject to receipt no later than 180 days after
6 the admission transaction has been completed.

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

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

25 The Illinois Department shall enter into agreements with
26 State agencies and departments, and is authorized to enter

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

16 Beginning in fiscal year 2013, the Illinois Department
17 shall set forth a request for information to identify the
18 benefits of a pre-payment, post-adjudication, and post-edit
19 claims system with the goals of streamlining claims processing
20 and provider reimbursement, reducing the number of pending or
21 rejected claims, and helping to ensure a more transparent
22 adjudication process through the utilization of: (i) provider
23 data verification and provider screening technology; and (ii)
24 clinical code editing; and (iii) pre-pay, pre-adjudicated, or
25 post-adjudicated predictive modeling with an integrated case
26 management system with link analysis. Such a request for

1 information shall not be considered as a request for proposal
2 or as an obligation on the part of the Illinois Department to
3 take any action or acquire any products or services.

4 The Illinois Department shall establish policies,
5 procedures, standards and criteria by rule for the
6 acquisition, repair and replacement of orthotic and prosthetic
7 devices and durable medical equipment. Such rules shall
8 provide, but not be limited to, the following services: (1)
9 immediate repair or replacement of such devices by recipients;
10 and (2) rental, lease, purchase or lease-purchase of durable
11 medical equipment in a cost-effective manner, taking into
12 consideration the recipient's medical prognosis, the extent of
13 the recipient's needs, and the requirements and costs for
14 maintaining such equipment. Subject to prior approval, such
15 rules shall enable a recipient to temporarily acquire and use
16 alternative or substitute devices or equipment pending repairs
17 or replacements of any device or equipment previously
18 authorized for such recipient by the Department.
19 Notwithstanding any provision of Section 5-5f to the contrary,
20 the Department may, by rule, exempt certain replacement
21 wheelchair parts from prior approval and, for wheelchairs,
22 wheelchair parts, wheelchair accessories, and related seating
23 and positioning items, determine the wholesale price by
24 methods other than actual acquisition costs.

25 The Department shall require, by rule, all providers of
26 durable medical equipment to be accredited by an accreditation

1 organization approved by the federal Centers for Medicare and
2 Medicaid Services and recognized by the Department in order to
3 bill the Department for providing durable medical equipment to
4 recipients. No later than 15 months after the effective date
5 of the rule adopted pursuant to this paragraph, all providers
6 must meet the accreditation requirement.

7 In order to promote environmental responsibility, meet the
8 needs of recipients and enrollees, and achieve significant
9 cost savings, the Department, or a managed care organization
10 under contract with the Department, may provide recipients or
11 managed care enrollees who have a prescription or Certificate
12 of Medical Necessity access to refurbished durable medical
13 equipment under this Section (excluding prosthetic and
14 orthotic devices as defined in the Orthotics, Prosthetics, and
15 Pedorthics Practice Act and complex rehabilitation technology
16 products and associated services) through the State's
17 assistive technology program's reutilization program, using
18 staff with the Assistive Technology Professional (ATP)
19 Certification if the refurbished durable medical equipment:
20 (i) is available; (ii) is less expensive, including shipping
21 costs, than new durable medical equipment of the same type;
22 (iii) is able to withstand at least 3 years of use; (iv) is
23 cleaned, disinfected, sterilized, and safe in accordance with
24 federal Food and Drug Administration regulations and guidance
25 governing the reprocessing of medical devices in health care
26 settings; and (v) equally meets the needs of the recipient or

1 enrollee. The reutilization program shall confirm that the
2 recipient or enrollee is not already in receipt of the same or
3 similar equipment from another service provider, and that the
4 refurbished durable medical equipment equally meets the needs
5 of the recipient or enrollee. Nothing in this paragraph shall
6 be construed to limit recipient or enrollee choice to obtain
7 new durable medical equipment or place any additional prior
8 authorization conditions on enrollees of managed care
9 organizations.

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

1 2013, minimum level of care eligibility criteria for
2 institutional and home and community-based long term care; and
3 (v) no later than October 1, 2013, establish procedures to
4 permit long term care providers access to eligibility scores
5 for individuals with an admission date who are seeking or
6 receiving services from the long term care provider. In order
7 to select the minimum level of care eligibility criteria, the
8 Governor shall establish a workgroup that includes affected
9 agency representatives and stakeholders representing the
10 institutional and home and community-based long term care
11 interests. This Section shall not restrict the Department from
12 implementing lower level of care eligibility criteria for
13 community-based services in circumstances where federal
14 approval has been granted.

15 The Illinois Department shall develop and operate, in
16 cooperation with other State Departments and agencies and in
17 compliance with applicable federal laws and regulations,
18 appropriate and effective systems of health care evaluation
19 and programs for monitoring of utilization of health care
20 services and facilities, as it affects persons eligible for
21 medical assistance under this Code.

22 The Illinois Department shall report annually to the
23 General Assembly, no later than the second Friday in April of
24 1979 and each year thereafter, in regard to:

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

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

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

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

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

17 Rulemaking authority to implement Public Act 95-1045, if
18 any, is conditioned on the rules being adopted in accordance
19 with all provisions of the Illinois Administrative Procedure
20 Act and all rules and procedures of the Joint Committee on
21 Administrative Rules; any purported rule not so adopted, for
22 whatever reason, is unauthorized.

23 On and after July 1, 2012, the Department shall reduce any
24 rate of reimbursement for services or other payments or alter
25 any methodologies authorized by this Code to reduce any rate
26 of reimbursement for services or other payments in accordance

1 with Section 5-5e.

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

18 Notwithstanding any other provision of this Code to the
19 contrary, on or after July 1, 2015, all FDA approved forms of
20 medication assisted treatment prescribed for the treatment of
21 alcohol dependence or treatment of opioid dependence shall be
22 covered under both fee-for-service ~~fee for service~~ and managed
23 care medical assistance programs for persons who are otherwise
24 eligible for medical assistance under this Article and shall
25 not be subject to any (1) utilization control, other than
26 those established under the American Society of Addiction

1 Medicine patient placement criteria, (2) prior authorization
2 mandate, or (3) lifetime restriction limit mandate.

3 On or after July 1, 2015, opioid antagonists prescribed
4 for the treatment of an opioid overdose, including the
5 medication product, administration devices, and any pharmacy
6 fees or hospital fees related to the dispensing, distribution,
7 and administration of the opioid antagonist, shall be covered
8 under the medical assistance program for persons who are
9 otherwise eligible for medical assistance under this Article.

10 As used in this Section, "opioid antagonist" means a drug that
11 binds to opioid receptors and blocks or inhibits the effect of
12 opioids acting on those receptors, including, but not limited
13 to, naloxone hydrochloride or any other similarly acting drug
14 approved by the U.S. Food and Drug Administration. The
15 Department shall not impose a copayment on the coverage
16 provided for naloxone hydrochloride under the medical
17 assistance program.

18 Upon federal approval, the Department shall provide
19 coverage and reimbursement for all drugs that are approved for
20 marketing by the federal Food and Drug Administration and that
21 are recommended by the federal Public Health Service or the
22 United States Centers for Disease Control and Prevention for
23 pre-exposure prophylaxis and related pre-exposure prophylaxis
24 services, including, but not limited to, HIV and sexually
25 transmitted infection screening, treatment for sexually
26 transmitted infections, medical monitoring, assorted labs, and

1 counseling to reduce the likelihood of HIV infection among
2 individuals who are not infected with HIV but who are at high
3 risk of HIV infection.

4 A federally qualified health center, as defined in Section
5 1905(1)(2)(B) of the federal Social Security Act, shall be
6 reimbursed by the Department in accordance with the federally
7 qualified health center's encounter rate for services provided
8 to medical assistance recipients that are performed by a
9 dental hygienist, as defined under the Illinois Dental
10 Practice Act, working under the general supervision of a
11 dentist and employed by a federally qualified health center.

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

19 Subject to approval by the federal Centers for Medicare
20 and Medicaid Services of a Title XIX State Plan amendment
21 electing the Program of All-Inclusive Care for the Elderly
22 (PACE) as a State Medicaid option, as provided for by Subtitle
23 I (commencing with Section 4801) of Title IV of the Balanced
24 Budget Act of 1997 (Public Law 105-33) and Part 460
25 (commencing with Section 460.2) of Subchapter E of Title 42 of
26 the Code of Federal Regulations, PACE program services shall

1 become a covered benefit of the medical assistance program,
2 subject to criteria established in accordance with all
3 applicable laws.

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

9 Notwithstanding any other provision of this Code, within
10 12 months after June 2, 2022 (the effective date of Public Act
11 102-1037) and subject to federal approval, acupuncture
12 services performed by an acupuncturist licensed under the
13 Acupuncture Practice Act who is acting within the scope of his
14 or her license shall be covered under the medical assistance
15 program. The Department shall apply for any federal waiver or
16 State Plan amendment, if required, to implement this
17 paragraph. The Department may adopt any rules, including
18 standards and criteria, necessary to implement this paragraph.

19 Notwithstanding any other provision of this Code, the
20 medical assistance program shall, subject to appropriation and
21 federal approval, reimburse hospitals for costs associated
22 with a newborn screening test for the presence of
23 metachromatic leukodystrophy, as required under the Newborn
24 Metabolic Screening Act, at a rate not less than the fee
25 charged by the Department of Public Health. The Department
26 shall seek federal approval before the implementation of the

1 newborn screening test fees by the Department of Public
2 Health.

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

11 Notwithstanding any other provision of this Code,
12 medically necessary reconstructive services that are intended
13 to restore physical appearance shall be covered under the
14 medical assistance program for persons who are otherwise
15 eligible for medical assistance under this Article. As used in
16 this paragraph, "reconstructive services" means treatments
17 performed on structures of the body damaged by trauma to
18 restore physical appearance.

19 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;
20 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article
21 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,
22 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;
23 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.
24 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;
25 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.
26 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;

1 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.
2 1-1-24; revised 12-15-23.)

3 ARTICLE 10.

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

6 (305 ILCS 5/5-5.05h new)

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

21 ARTICLE 15.

1 Section 15-5. 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 (g) All applications for the expansion of supportive
10 living dementia care settings involving sites not approved by
11 the Department on January 1, 2024 (the effective date of
12 Public Act 103-102) ~~this amendatory Act of the 103rd General~~
13 ~~Assembly~~ may allow new elderly non-dementia units in addition
14 to new dementia care units. The Department may approve such
15 applications only if the application has: (1) no more than one
16 non-dementia care unit for each dementia care unit and (2) the
17 site is not located within 4 miles of an existing supportive
18 living program site in Cook County (including the City of
19 Chicago), not located within 12 miles of an existing
20 supportive living program site in DuPage County, Kane County,
21 Lake County, McHenry County, or Will County, or not located
22 within 25 miles of an existing supportive living program site
23 in any other county.

24 (h) Beginning January 1, 2025, subject to federal
25 approval, for a person who is a resident of a supportive living
26 facility under this Section, the monthly personal needs

1 allowance shall be \$120 per month.

2 (Source: P.A. 102-43, eff. 7-6-21; 102-699, eff. 4-19-22;
3 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102,
4 Article 100, Section 100-5, eff. 1-1-24; revised 12-15-23.)

5 ARTICLE 20.

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

8 (210 ILCS 170/40)

9 Sec. 40. Reimbursement requirements.

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

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

20 ~~(1) a professional fee for both the birthing person~~
21 ~~and baby;~~

22 ~~(2) a facility fee for the birthing person that is no~~
23 ~~less than 75% of the statewide average facility payment~~

1 ~~rate made to a hospital for an uncomplicated vaginal~~
2 ~~birth;~~

3 ~~(3) a facility fee for the baby that is no less than~~
4 ~~75% of the statewide average facility payment rate made to~~
5 ~~a hospital for a normal baby; and~~

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

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

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

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

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

17 (305 ILCS 5/5-18.3 new)

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

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

22 (1) Beginning January 1, 2025, subject to federal
23 approval, a facility fee for the birthing person and baby
24 that is no less than 80% of the statewide average facility

1 payment rate made to a hospital for an uncomplicated
2 vaginal birth. The facility fee shall include medications,
3 laboratory tests, and supplies provided.

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

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

14 ARTICLE 30.

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

17 (305 ILCS 5/5H-1)

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

19 "Base year" means the 12-month period from January 1, 2023
20 ~~2018~~ to December 31, 2023 ~~2018~~.

21 "Department" means the Department of Healthcare and Family
22 Services.

23 "Federal employee health benefit" means the program of

1 health benefits plans, as defined in 5 U.S.C. 8901, available
2 to federal employees under 5 U.S.C. 8901 to 8914.

3 "Fund" means the Healthcare Provider Relief Fund.

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

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

15 "Medicare" means the federal Medicare program established
16 under Title XVIII of the federal Social Security Act.

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

1 dental or vision plans, a Medicare Advantage Plan, a Medicare
2 Supplement Plan, a Medicaid Medicare Alignment Initiative Plan
3 pursuant to a Memorandum of Understanding between the
4 Department and the Federal Centers for Medicare and Medicaid
5 Services or a Federal Employee Health Benefits Plan.

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

7 (305 ILCS 5/5H-3)

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

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

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

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

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

16 (b) The tiers are established as follows:

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

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

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

25 (c) For State fiscal year 2020, and for each State fiscal

1 year thereafter, ~~through State fiscal year 2025,~~ the
2 Department may ~~by rule~~ adjust rates or tier parameters or both
3 in order to maximize the revenue generated by the assessment
4 consistent with federal regulations and to meet federal
5 statistical tests necessary for federal financial
6 participation. Any upward adjustment to the Tier 3 rate shall
7 be the minimum necessary to meet federal statistical tests.

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

9 ARTICLE 35.

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

12 (5 ILCS 100/5-45.55 new)

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

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

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

5 (305 ILCS 5/14-12.5)

6 Sec. 14-12.5. Hospital rate updates.

7 (a) Notwithstanding any other provision of this Code, the
8 hospital rates of reimbursement authorized under Sections
9 5-5.05, 14-12, and 14-13 of this Code shall be adjusted in
10 accordance with the provisions of this Section.

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

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

19 (2) For inpatient psychiatric services:

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

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

15 (C) For all psychiatric specialty hospitals, the
16 per diem rates in effect January 1, 2023, shall be
17 increased by 10%, except that all rates shall be at
18 least 90% of the minimum inpatient per diem rate for
19 safety-net hospitals as authorized in subsection (b-5)
20 of Section 5-5.05 of this Code, including the
21 adjustments authorized in this Section. The statewide
22 default per diem rate for a new psychiatric specialty
23 hospital shall be set at 90% of the minimum inpatient
24 psychiatric care per diem rate for safety-net
25 hospitals as authorized in subsection (b-5) of Section
26 5-5.05 of this Code, including the adjustment

1 authorized in this Section.

2 (3) For inpatient rehabilitative services, all
3 hospital specific per diem rates in effect January 1,
4 2023, shall be increased by 10%. The statewide default
5 inpatient rehabilitative services per diem rates, for
6 general acute care hospitals and for rehabilitation
7 specialty hospitals respectively, shall be increased by
8 10%.

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

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

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

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

21 (8) For services provided ~~Beginning~~ on and after
22 January 1, 2024 through June 30, 2024, and on and after
23 January 1, 2027, subject to federal approval, in addition
24 to the statewide standardized amount, an add-on payment of
25 at least \$210 shall be paid for each inpatient General
26 Acute and Psychiatric day of care, excluding

1 Medicare-Medicaid dual eligible crossover days, for all
2 safety-net hospitals defined in Section 5-5e.1 of this
3 Code.

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

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

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

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

1 in Section 5-5e.1 of this Code, as follows:

2 (A) if the safety-net hospital's Medicaid
3 inpatient utilization rate, as calculated under
4 Section 5-5e.1 of this Code, is equal to or greater
5 than 70%, the add-on payment shall be \$425;

6 (B) if the safety-net hospital's Medicaid
7 inpatient utilization rate, as calculated under
8 Section 5-5e.1 of this Code, is equal to or greater
9 than 50% and less than 70%, the add-on payment shall be
10 \$300;

11 (C) if the safety-net hospital's Medicaid
12 inpatient utilization rate, as calculated under
13 Section 5-5e.1 of this Code, is equal to or greater
14 than 40% and less than 50%, the add-on payment shall be
15 \$225; and

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

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

24 Rates described in subparagraphs (A) through (C) shall
25 be adjusted annually beginning January 1, 2026 by applying
26 a uniform factor to each rate to spend an approximate

1 amount of \$50,000,000 annually per year using State fiscal
2 year 2024 days as a basis for calendar year 2026 rates.

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

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

25 (c) The Department shall take all actions necessary to
26 ensure the changes authorized in Public Act 103-102 and this

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

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

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

26 (f) The Department shall publish updated rate sheets or

1 add-on payment amounts, as applicable, for all hospitals 30
2 days prior to the effective date of the rate increase, or
3 within 30 days after federal approval by the Centers for
4 Medicare and Medicaid Services, whichever is later.

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

6 ARTICLE 40.

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

9 (305 ILCS 5/5A-12.7)

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

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

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

1 Social Security Act. In determining the hospital access
2 payments authorized under subsection (g) of this Section, if a
3 hospital ceases to qualify for payments from the pool, the
4 payments for all hospitals continuing to qualify for payments
5 from such pool shall be uniformly adjusted to fully expend the
6 aggregate net amount of the pool, with such adjustment being
7 effective on the first day of the second month following the
8 date the hospital ceases to receive payments from such pool.

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

12 (c) Graduate medical education.

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

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

1 hospital's total days (Worksheet S3 Part I, Column 8,
2 Lines 14, 16-18, and 32).

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

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

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

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

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

24 (1) For critical access hospitals, \$385 per covered
25 inpatient day contained in paid fee-for-service claims and
26 \$530 per paid fee-for-service outpatient claim for dates

1 of service in Calendar Year 2019 in the Department's
2 Enterprise Data Warehouse as of May 11, 2020.

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

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

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

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

22 (6) For all general acute care hospitals and high
23 Medicaid hospitals as defined in subsection (f), \$350 per
24 covered inpatient day for dates of service in Calendar
25 Year 2019 contained in paid fee-for-service claims and
26 \$620 per paid fee-for-service outpatient claim in the

1 Department's Enterprise Data Warehouse as of May 11, 2020.

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

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

1 with the federal upper payment limits, with such adjustments
2 being determined so that the total estimated spending by
3 hospital class, under such adjusted rates, remains
4 substantially similar to the total estimated spending under
5 the original rates set forth in this subsection.

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

12 (2) For safety-net hospitals, as described in
13 subsection (f), \$1,350 per inpatient day contained in paid
14 fee-for-service claims and \$1,350 per paid fee-for-service
15 outpatient claim for dates of service in Calendar Year
16 2019 in the Department's Enterprise Data Warehouse as of
17 August 6, 2021.

18 (3) For long term acute care hospitals, \$550 per
19 covered inpatient day contained in paid fee-for-service
20 claims for dates of service in Calendar Year 2019 in the
21 Department's Enterprise Data Warehouse as of August 6,
22 2021.

23 (4) For freestanding psychiatric hospitals, \$200 per
24 covered inpatient day contained in paid fee-for-service
25 claims and \$200 per paid fee-for-service outpatient claim
26 for dates of service in Calendar Year 2019 in the

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

3 (5) For freestanding rehabilitation hospitals, \$550
4 per covered inpatient day contained in paid
5 fee-for-service claims and \$125 per paid fee-for-service
6 outpatient claim for dates of service in Calendar Year
7 2019 in the Department's Enterprise Data Warehouse as of
8 August 6, 2021.

9 (6) For all general acute care hospitals and high
10 Medicaid hospitals as defined in subsection (f), \$500 per
11 covered inpatient day for dates of service in Calendar
12 Year 2019 contained in paid fee-for-service claims and
13 \$500 per paid fee-for-service outpatient claim in the
14 Department's Enterprise Data Warehouse as of August 6,
15 2021.

16 (7) For public hospitals, as defined in subsection
17 (f), \$275 per covered inpatient day contained in paid
18 fee-for-service claims and \$275 per paid fee-for-service
19 outpatient claim for dates of service in Calendar Year
20 2019 in the Department's Enterprise Data Warehouse as of
21 August 6, 2021.

22 (8) 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 Calendar Year 2019 total
6 inpatient fee-for-service days, in the Department's
7 Enterprise Data Warehouse as of August 6, 2021, multiplied
8 by the applicable Alzheimer's treatment rate of \$244.37
9 for hospitals located in Cook County and \$312.03 for
10 hospitals located outside Cook County.

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

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

1 calculations and reports shall be posted no later than the
2 first day of the quarter for which the payments are to be
3 issued.

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

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

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

25 (C) Long term acute care hospitals.

26 (D) Freestanding psychiatric hospitals.

1 (E) Freestanding rehabilitation hospitals.

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

7 (G) High Medicaid hospitals.

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

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

1 children's hospitals and affiliated general acute
2 care hospitals shall be considered a single
3 hospital.

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

1 Department shall use dates of service from the
2 State fiscal year ending 18 month before the
3 beginning of the first Payout Quarter of the
4 subsequent annual determination period.

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

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

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

22 (3) Beginning January 1, 2024, the Department may reassign
23 hospitals or entire hospital classes as defined above, if
24 federal limits on the payments to the class to which the
25 hospitals are assigned based on the criteria in this
26 subsection prevent the Department from making payments to the

1 class that would otherwise be due under this Section. The
2 Department shall publish the criteria and composition of each
3 new class based on the reassignments, and the projected impact
4 on payments to each hospital under the new classes on its
5 website by November 15 of the year before the year in which the
6 class changes become effective.

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

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

25 (A) Each hospital in the class shall have a
26 quarterly inpatient directed payment calculated that

1 is equal to the product of the number of inpatient days
2 attributable to the hospital used in the calculation
3 of the quarterly uniform class per diem add-on,
4 multiplied by the calculated applicable quarterly
5 uniform class per diem add-on of the hospital class.

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

10 (2) Outpatient per unit add-on. A quarterly uniform
11 per claim add-on shall be derived by dividing the
12 quarterly Outpatient Directed Payments Pool amount
13 allocated to the applicable hospital class by the total
14 outpatient 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 outpatient directed payment calculated that
18 is equal to the product of the number of outpatient
19 encounter claims attributable to the hospital used in
20 the calculation of the quarterly uniform class per
21 claim add-on, multiplied by the calculated applicable
22 quarterly uniform class per claim add-on of the
23 hospital class.

24 (B) Each hospital shall be paid 1/3 of its
25 quarterly outpatient directed payment in each of the 3
26 months of the Payout Quarter, in accordance with

1 directions provided to each MCO by the Department.

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

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

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

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

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

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

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

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

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

23 (6) For the period January 1, 2023 through December
24 31, 2023, the Department shall establish the amounts that
25 shall be allocated to the hospital class directed payment
26 fixed pools identified in this paragraph for the quarterly

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

13 (A) Hospital inpatient services for critical
14 access hospitals.

15 (B) Hospital outpatient services for critical
16 access hospitals.

17 (C) Hospital inpatient services for public
18 hospitals.

19 (D) Hospital outpatient services for public
20 hospitals.

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

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

25 (7) Semi-annual rate maintenance review. The
26 Department shall ensure that hospitals assigned to the

1 fixed pools in paragraph (6) are paid no less than 95% of
2 the annual initial rate for each 6-month period of each
3 annual payout period. For each calendar year, the
4 Department shall calculate the annual initial rate per day
5 and per visit for each fixed pool hospital class listed in
6 paragraph (6), by dividing the total of all applicable
7 inpatient or outpatient directed payments issued in the
8 preceding calendar year to the hospitals in each fixed
9 pool class for the calendar year, plus any increase
10 resulting from the annual adjustments described in
11 subsection (i), by the actual applicable total service
12 units for the preceding calendar year which were the basis
13 of the total applicable inpatient or outpatient directed
14 payments issued to the hospitals in each fixed pool class
15 in the calendar year, except that for calendar year 2023,
16 the service units from calendar year 2021 shall be used.

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

24 (B) If the effective rate calculated in
25 subparagraph (A) is less than 95% of the annual
26 initial rate assigned to the class for each pool under

1 paragraph (6), the Department shall adjust the payment
2 for each hospital to a level equal to no less than 95%
3 of the annual initial rate, by issuing a retroactive
4 adjustment payment for the 6-month period under review
5 as identified in subparagraph (A).

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

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

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

1 category of service 21 for the determination quarter.

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

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

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

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

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

1 category of service 20 for the determination quarter.

2 (8) For high Medicaid hospitals an amount equal to
3 \$160 multiplied by the hospital's category of service 21
4 case mix index for the determination quarter multiplied by
5 the hospital's total number of inpatient admissions for
6 category of service 21 for the determination quarter.

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

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

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

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

1 EAPGs for the determination quarter.

2 (13) For long term acute care hospitals the amount of
3 \$495 multiplied by the hospital's total number of
4 inpatient days for the determination quarter.

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

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

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

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

21 (18) Effective for the Payout Quarter beginning
22 January 1, 2023, for the directed payments to hospitals
23 required under this subsection, the Department shall
24 establish the amounts that shall be used to calculate such
25 directed payments using the methodologies specified in
26 this paragraph. The Department shall use a single, uniform

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

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

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

25 Notwithstanding any other provision of this subsection, if
26 the Department determines that the actual total hospital

1 utilization data that is used to calculate the fixed rate
2 directed payments is substantially different than anticipated
3 when the rates in this subsection were initially determined
4 for unforeseeable circumstances (such as the COVID-19 pandemic
5 or some other public health emergency), the Department may
6 adjust the rates specified in this subsection so that the
7 total directed payments approximate the total spending amount
8 anticipated when the rates were initially established.

9 Definitions. As used in this subsection:

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

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

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

1 associated claims.

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

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

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

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

5 (j) Pass-through payments.

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

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

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

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

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

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

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

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

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

26 (3) For the calendar year beginning January 1, 2023,

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

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

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

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

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

21 (n) In order to address the escalating infant mortality
22 rates among minority communities in Illinois, the State shall,
23 subject to appropriation, create a pool of funding of at least
24 \$50,000,000 annually to be disbursed among safety-net
25 hospitals that maintain perinatal designation from the
26 Department of Public Health. The funding shall be used to

1 preserve or enhance OB/GYN services or other specialty
2 services at the receiving hospital, with the distribution of
3 funding to be established by rule and with consideration to
4 perinatal hospitals with safe birthing levels and quality
5 metrics for healthy mothers and babies.

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

22 (p) For calendar year 2023, the final amounts, rates, and
23 payments under subsections (c), (d-2), (g), (h), and (j) shall
24 be established by the Department, so that the sum of the total
25 estimated annual payments under subsections (c), (d-2), (g),
26 (h), and (j) for each hospital class for calendar year 2023, is

1 no less than:

2 (1) \$858,260,000 to safety-net hospitals.

3 (2) \$86,200,000 to critical access hospitals.

4 (3) \$1,765,000,000 to high Medicaid hospitals.

5 (4) \$673,860,000 to general acute care hospitals.

6 (5) \$48,330,000 to long term acute care hospitals.

7 (6) \$89,110,000 to freestanding psychiatric hospitals.

8 (7) \$24,300,000 to freestanding rehabilitation
9 hospitals.

10 (8) \$32,570,000 to public hospitals.

11 (q) Hospital Pandemic Recovery Stabilization Payments. The
12 Department shall disburse a pool of \$460,000,000 in stability
13 payments to hospitals prior to April 1, 2023. The allocation
14 of the pool shall be based on the hospital directed payment
15 classes and directed payments issued, during Calendar Year
16 2022 with added consideration to safety net hospitals, as
17 defined in subdivision (f)(1)(B) of this Section, and critical
18 access hospitals.

19 (Source: P.A. 102-4, eff. 4-27-21; 102-16, eff. 6-17-21;
20 102-886, eff. 5-17-22; 102-1115, eff. 1-9-23; 103-102, eff.
21 6-16-23; revised 9-21-23.)

22 ARTICLE 45.

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

1 (305 ILCS 5/5-5.08a new)

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

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

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

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

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

23 (b) Subject to federal approval, for dates of service
24 beginning on and after January 1, 2025, for home renal
25 dialysis provided to residents of skilled nursing facilities,

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

12 ARTICLE 50.

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

15 (305 ILCS 5/5-5.07)

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

1 provisions for another living arrangement for the child or the
2 child's discharge is being delayed due to a pending inquiry or
3 investigation by the Department of Children and Family
4 Services. If any portion of a hospital stay is reimbursed
5 under this Section, the hospital stay shall not be eligible
6 for payment under the provisions of Section 14-13 of this
7 Code.

8 (Source: Reenacted by P.A. 101-15, eff. 6-14-19; reenacted by
9 P.A. 101-209, eff. 8-5-19; P.A. 101-655, eff. 3-12-21;
10 102-201, eff. 7-30-21; 102-558, eff. 8-20-21; 102-1037, eff.
11 6-2-22.)

12 (305 ILCS 5/14-13)

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

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

25 (b) The methodology shall provide reasonable compensation

1 for the services provided attributable to the days of the
2 extended stay for which the prevailing rate methodology
3 provides no reimbursement. The Department may use a day
4 outlier program to satisfy this requirement. The reimbursement
5 rate shall be set at a level so as not to act as an incentive
6 to avoid transfer to the appropriate level of care needed or
7 placement, after discharge.

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

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

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

1 hours after admission that the hospital fails to notify the
2 managed care organization of the admission, reimbursement
3 under this subsection shall be reduced by one day.

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

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

13 ARTICLE 55.

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

16 (305 ILCS 5/5-55 new)

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

1 Music Therapy Licensing and Practice Act.

2 ARTICLE 60.

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

5 (305 ILCS 5/5-60 new)

6 Sec. 5-60. Optometric services; reimbursement rates.

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

14 ARTICLE 65.

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

17 (305 ILCS 5/5-2.06)

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

1 individuals, reimburse Children's Community-Based Health Care
2 Centers established in the Alternative Health Care Delivery
3 Act and providing nursing care for the purpose of
4 transitioning children from a hospital to home placement or
5 other appropriate setting and reuniting families for a maximum
6 of up to 120 days on a per diem basis at the lower of the
7 Children's Community-Based Health Care Center's usual and
8 customary charge to the public or at the Department rate of
9 \$1,300 ~~\$950~~. Payments at the rate set forth in this Section are
10 exempt from the 2.7% rate reduction required under Section
11 5-5e.

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

13 ARTICLE 70.

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

16 (305 ILCS 5/5-5.24a new)

17 Sec. 5-5.24a. Remote ultrasounds and remote fetal
18 nonstress tests; reimbursement.

19 (a) Subject to federal approval, for dates of service
20 beginning on and after January 1, 2025, the Department shall
21 reimburse for remote ultrasound procedures and remote fetal
22 nonstress tests when the patient is in a residence or other
23 off-site location from the patient's provider and the same

1 standard of care is met as would be present during an in-person
2 visit.

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

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

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

12 (3) that is approved by the U.S. Food and Drug
13 Administration.

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

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

22 ARTICLE 75.

23 Section 75-5. The Illinois Public Aid Code is amended by
24 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

1 eligible for medical assistance under this Section shall be
2 20% higher than the reimbursement rates in effect for nursing
3 services on December 31, 2023.

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

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

13 ARTICLE 80.

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

16 (305 ILCS 5/5-52 new)

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

1 ARTICLE 85.

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

4 (305 ILCS 5/5-4.2)

5 Sec. 5-4.2. Ambulance services payments.

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

1 the statutes, laws, regulations, policies, procedures,
2 principles, definitions, guidelines, and manuals used to
3 determine the amounts paid to ambulance service providers
4 under Title XVIII of the Social Security Act (Medicare).

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

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

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

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

1 services, or both. For purposes of this Section, this includes
2 both ambulance providers and ambulance suppliers as described
3 by the Centers for Medicare and Medicaid Services.

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

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

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

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

23 (e) Beginning with services rendered on or after July 1,
24 2008, all providers of non-emergency medi-car and service car
25 transportation must certify that the driver and employee
26 attendant, as applicable, have completed a safety program

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

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

25 (f) With respect to any policy or program administered by
26 the Department or its agent regarding approval of

1 non-emergency medical transportation by ground ambulance
2 service providers, including, but not limited to, the
3 Non-Emergency Transportation Services Prior Approval Program
4 (NETSPAP), the Department shall establish by rule a process by
5 which ground ambulance service providers of non-emergency
6 medical transportation may appeal any decision by the
7 Department or its agent for which no denial was received prior
8 to the time of transport that either (i) denies a request for
9 approval for payment of non-emergency transportation by means
10 of ground ambulance service or (ii) grants a request for
11 approval of non-emergency transportation by means of ground
12 ambulance service at a level of service that entitles the
13 ground ambulance service provider to a lower level of
14 compensation from the Department than the ground ambulance
15 service provider would have received as compensation for the
16 level of service requested. The rule shall be filed by
17 December 15, 2012 and shall provide that, for any decision
18 rendered by the Department or its agent on or after the date
19 the rule takes effect, the ground ambulance service provider
20 shall have 60 days from the date the decision is received to
21 file an appeal. The rule established by the Department shall
22 be, insofar as is practical, consistent with the Illinois
23 Administrative Procedure Act. The Director's decision on an
24 appeal under this Section shall be a final administrative
25 decision subject to review under the Administrative Review
26 Law.

1 (f-5) Beginning 90 days after July 20, 2012 (the effective
2 date of Public Act 97-842), (i) no denial of a request for
3 approval for payment of non-emergency transportation by means
4 of ground ambulance service, and (ii) no approval of
5 non-emergency transportation by means of ground ambulance
6 service at a level of service that entitles the ground
7 ambulance service provider to a lower level of compensation
8 from the Department than would have been received at the level
9 of service submitted by the ground ambulance service provider,
10 may be issued by the Department or its agent unless the
11 Department has submitted the criteria for determining the
12 appropriateness of the transport for first notice publication
13 in the Illinois Register pursuant to Section 5-40 of the
14 Illinois Administrative Procedure Act.

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

26 (f-7) For non-emergency ground ambulance claims properly

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

20 (g) Whenever a patient covered by a medical assistance
21 program under this Code or by another medical program
22 administered by the Department, including a patient covered
23 under the State's Medicaid managed care program, is being
24 transported from a facility and requires non-emergency
25 transportation including ground ambulance, medi-car, or
26 service car transportation, a Physician Certification

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

26 The medical certification specifying the level and type of

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

1 the Department of Healthcare and Family Services.

2 Pursuant to subsection (E) of Section 12-4.25 of this
3 Code, the Department is entitled to recover overpayments paid
4 to a provider or vendor, including, but not limited to, from
5 the discharging physician, the discharging facility, and the
6 ground ambulance service provider, in instances where a
7 non-emergency ground ambulance service is rendered as the
8 result of improper or false certification.

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

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

23 (i) Subject to federal approval, on and after January 1,
24 2024 ~~through June 30, 2026~~, the Department shall increase the
25 base rate of reimbursement for both base charges and mileage
26 charges for ground ambulance service providers not

1 participating in the Ground Emergency Medical Transportation
2 (GEMT) Program for medical transportation services provided by
3 means of a ground ambulance to a level not lower than 140% of
4 the base rate in effect as of January 1, 2023.

5 (j) For the purpose of understanding ground ambulance
6 transportation services cost structures and their impact on
7 the Medical Assistance Program, the Department shall engage
8 stakeholders, including, but not limited to, a statewide
9 association representing private ground ambulance service
10 providers in Illinois, to develop recommendations for a plan
11 for the regular collection of cost data for all ground
12 ambulance transportation providers reimbursed under the
13 Illinois Title XIX State Plan. Cost data obtained through this
14 process shall be used to inform on and to ensure the
15 effectiveness and efficiency of Illinois Medicaid rates. The
16 Department shall establish a process to limit public
17 availability of portions of the cost report data determined to
18 be proprietary. This process shall be concluded and
19 recommendations shall be provided no later than December 31,
20 2025 ~~April 1, 2024~~.

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

1 in effect on January 1, 2023.

2 (Source: P.A. 102-364, eff. 1-1-22; 102-650, eff. 8-27-21;
3 102-813, eff. 5-13-22; 102-1037, eff. 6-2-22; 103-102, Article
4 70, Section 70-5, eff. 1-1-24; 103-102, Article 80, Section
5 80-5, eff. 1-1-24; revised 12-15-23.)

6 ARTICLE 90.

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

9 (305 ILCS 5/5-5)

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

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

1 arising from the sexual assault; (16) the diagnosis and
2 treatment of sickle cell anemia; (16.5) services performed by
3 a chiropractic physician licensed under the Medical Practice
4 Act of 1987 and acting within the scope of his or her license,
5 including, but not limited to, chiropractic manipulative
6 treatment; and (17) any other medical care, and any other type
7 of remedial care recognized under the laws of this State. The
8 term "any other type of remedial care" shall include nursing
9 care and nursing home service for persons who rely on
10 treatment by spiritual means alone through prayer for healing.

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

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

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

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

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

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

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

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

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

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

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

25 Notwithstanding any other provision of this Code and
26 subject to federal approval, the Department may adopt rules to

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

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

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 breast tomosynthesis.

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

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

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

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

1 of the provision set forth in this paragraph.

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

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

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

1 metropolitan Chicago. An evaluation of the pilot program shall
2 be carried out measuring health outcomes and cost of care for
3 those served by the pilot program compared to similarly
4 situated patients who are not served by the pilot program.

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

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

24 On or after July 1, 2022, individuals who are otherwise
25 eligible for medical assistance under this Article shall
26 receive coverage for perinatal depression screenings for the

1 12-month period beginning on the last day of their pregnancy.
2 Medical assistance coverage under this paragraph shall be
3 conditioned on the use of a screening instrument approved by
4 the Department.

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

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

24 The Illinois Department, in cooperation with the
25 Departments of Human Services (as successor to the Department
26 of Alcoholism and Substance Abuse) and Public Health, through

1 a public awareness campaign, may provide information
2 concerning treatment for alcoholism and drug abuse and
3 addiction, prenatal health care, and other pertinent programs
4 directed at reducing the number of drug-affected infants born
5 to recipients of medical assistance.

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

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

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

1 require that the sponsor organization be a medical
2 organization.

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

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

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

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

25 Medical providers shall be required to meet certain
26 qualifications to participate in Partnerships to ensure the

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

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

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

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

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

1 (the effective date of Public Act 83-1439), the Illinois
2 Department shall establish a current list of acquisition costs
3 for all prosthetic devices and any other items recognized as
4 medical equipment and supplies reimbursable under this Article
5 and shall update such list on a quarterly basis, except that
6 the acquisition costs of all prescription drugs shall be
7 updated no less frequently than every 30 days as required by
8 Section 5-5.12.

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

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

1 Department shall have an additional 365 days to test the
2 viability of the new system and to ensure that any necessary
3 operational or structural changes to its information
4 technology platforms are implemented.

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

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

22 Enrollment of a vendor shall be subject to a provisional
23 period and shall be conditional for one year. During the
24 period of conditional enrollment, the Department may terminate
25 the vendor's eligibility to participate in, or may disenroll
26 the vendor from, the medical assistance program without cause.

1 Unless otherwise specified, such termination of eligibility or
2 disenrollment is not subject to the Department's hearing
3 process. However, a disenrolled vendor may reapply without
4 penalty.

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

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

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

1 hearing rights, if any, afforded to a vendor in each category
2 of risk of the vendor that is terminated or disenrolled during
3 the conditional enrollment period.

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

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

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

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

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

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

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

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

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

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

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

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

20 The Illinois Department shall establish policies,
21 procedures, standards and criteria by rule for the
22 acquisition, repair and replacement of orthotic and prosthetic
23 devices and durable medical equipment. Such rules shall
24 provide, but not be limited to, the following services: (1)
25 immediate repair or replacement of such devices by recipients;
26 and (2) rental, lease, purchase or lease-purchase of durable

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

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

23 In order to promote environmental responsibility, meet the
24 needs of recipients and enrollees, and achieve significant
25 cost savings, the Department, or a managed care organization
26 under contract with the Department, may provide recipients or

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

26 The Department shall execute, relative to the nursing home

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

1 interests. This Section shall not restrict the Department from
2 implementing lower level of care eligibility criteria for
3 community-based services in circumstances where federal
4 approval has been granted.

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

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

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

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

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

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

23 The period covered by each report shall be the 3 years
24 ending on the June 30 prior to the report. The report shall
25 include suggested legislation for consideration by the General
26 Assembly. The requirement for reporting to the General

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

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

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

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

1 under Section 5-2 of this Code. To qualify for coverage of
2 kidney transplantation, such person must be receiving
3 emergency renal dialysis services covered by the Department.
4 Providers under this Section shall be prior approved and
5 certified by the Department to perform kidney transplantation
6 and the services under this Section shall be limited to
7 services associated with kidney transplantation.

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

19 On or after July 1, 2015, opioid antagonists prescribed
20 for the treatment of an opioid overdose, including the
21 medication product, administration devices, and any pharmacy
22 fees or hospital fees related to the dispensing, distribution,
23 and administration of the opioid antagonist, shall be covered
24 under the medical assistance program for persons who are
25 otherwise eligible for medical assistance under this Article.
26 As used in this Section, "opioid antagonist" means a drug that

1 binds to opioid receptors and blocks or inhibits the effect of
2 opioids acting on those receptors, including, but not limited
3 to, naloxone hydrochloride or any other similarly acting drug
4 approved by the U.S. Food and Drug Administration. The
5 Department shall not impose a copayment on the coverage
6 provided for naloxone hydrochloride under the medical
7 assistance program.

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

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

1 dentist and employed by a federally qualified health center.

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

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

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

25 Notwithstanding any other provision of this Code, within
26 12 months after June 2, 2022 (the effective date of Public Act

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

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

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

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

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

19 ARTICLE 95.

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

22 (210 ILCS 49/5-107)

23 Sec. 5-107. Quality of life enhancement. Beginning on July

1 1, 2019, for improving the quality of life and the quality of
2 care, an additional payment shall be awarded to a facility for
3 their single occupancy rooms. This payment shall be in
4 addition to the rate for recovery and rehabilitation. The
5 additional rate for single room occupancy shall be no less
6 than \$10 per day, per single room occupancy. The Department of
7 Healthcare and Family Services shall adjust payment to
8 Medicaid managed care entities to cover these costs. Beginning
9 July 1, 2022, for improving the quality of life and the quality
10 of care, a payment of no less than \$5 per day, per single room
11 occupancy shall be added to the existing \$10 additional per
12 day, per single room occupancy rate for a total of at least \$15
13 per day, per single room occupancy. For improving the quality
14 of life and the quality of care, on January 1, 2024, a payment
15 of no less than \$10.50 per day, per single room occupancy shall
16 be added to the existing \$15 additional per day, per single
17 room occupancy rate for a total of at least \$25.50 per day, per
18 single room occupancy. For improving the quality of life and
19 the quality of care, beginning on January 1, 2025, a payment of
20 no less than \$10 per day, per single room occupancy shall be
21 added to the existing \$25.50 additional per day, per single
22 room occupancy rate for a total of at least \$35.50 per day, per
23 single room occupancy. Beginning July 1, 2022, for improving
24 the quality of life and the quality of care, an additional
25 payment shall be awarded to a facility for its dual-occupancy
26 rooms. This payment shall be in addition to the rate for

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

14 (Source: P.A. 102-699, eff. 4-19-22; 103-102, eff. 1-1-24.)

15 ARTICLE 100.

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

18 (305 ILCS 5/5-5.01a)

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

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

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

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

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

25 The Medicaid rates for supportive living facilities
26 effective on July 1, 2017 must be equal to the rates in effect

1 for supportive living facilities on June 30, 2017 increased by
2 2.8%.

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

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

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

26 (c) The Department may adopt rules to implement this

1 Section. Rules that establish or modify the services,
2 standards, and conditions for participation in the program
3 shall be adopted by the Department in consultation with the
4 Department on Aging, the Department of Rehabilitation
5 Services, and the Department of Mental Health and
6 Developmental Disabilities (or their successor agencies).

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

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

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

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

25 (4) those distinct parts of the site or building do
26 not share staffing with the part of the building used for

1 the provision of supportive living program services.

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

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

26 (g) All applications for the expansion of supportive

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

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

23 ARTICLE 105.

24 Section 105-5. The Illinois Public Aid Code is amended by

1 changing Section 5-36 as follows:

2 (305 ILCS 5/5-36)

3 Sec. 5-36. Pharmacy benefits.

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

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

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

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

24 (C) the Department's third-party administrator shall
25 not create, modify, implement, or indirectly establish any

1 fee on a pharmacy, pharmacist, or a recipient of medical
2 assistance without written approval by the Department.

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

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

21 (c) On at least an annual basis, the Director of the
22 Department of Healthcare and Family Services shall submit a
23 report beginning no later than one year after January 1, 2020
24 (the effective date of Public Act 101-452) that provides an
25 update on any contract, contract issues, formulary, dispensing
26 fees, and maximum allowable cost concerns regarding a

1 third-party administrator and managed care. The requirement
2 for reporting to the General Assembly shall be satisfied by
3 filing copies of the report with the Speaker, the Minority
4 Leader, and the Clerk of the House of Representatives and with
5 the President, the Minority Leader, and the Secretary of the
6 Senate. The Department shall take care that no proprietary
7 information is included in the report required under this
8 Section.

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

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

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

25 (2) the percentage of claims payments made by the
26 pharmacy benefit manager to pharmacies owned, managed, or

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

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

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

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

20 (6) the aggregate wholesale acquisition cost for drugs
21 that were dispensed to enrollees in each MCO with which
22 the pharmacy benefit manager has a contract by any
23 pharmacy owned, managed, or controlled by the pharmacy
24 benefit manager or any of the pharmacy benefit manager's
25 management companies, parent companies, subsidiary
26 companies, or jointly-held companies;

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

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

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

12 (10) any other information considered necessary by the
13 Department.

14 (f) The information disclosed under subsection (e) shall
15 include all retail, mail order, specialty, and compounded
16 prescription products. All information made available to the
17 Department under subsection (e) is confidential and not
18 subject to disclosure under the Freedom of Information Act.
19 All information made available to the Department under
20 subsection (e) shall not be reported or distributed in any way
21 that compromises its competitive, proprietary, or financial
22 value. The information shall only be used by the Department to
23 assess the contract, agreement, or other arrangements made
24 between a pharmacy benefit manager and a pharmacy provider,
25 pharmaceutical manufacturer or labeler, managed care
26 organization, or other entity, as applicable.

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

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

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

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

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

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

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

26 (3) prevents or interferes with an individual's choice

1 to receive a prescription drug from a 340B entity or 340B
2 pharmacy through any legally permissible means;

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

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

15 (6) any other provision that discriminates against a
16 340B entity or 340B pharmacy by treating a 340B entity or
17 340B pharmacy differently than non-340B entities or
18 non-340B pharmacies for any reason relating to the
19 entity's participation in the 340B drug discount program.

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

24 In this subsection (h-5):

25 "340B entity" means a covered entity as defined in 42
26 U.S.C. 256b(a)(4) authorized to participate in the 340B drug

1 discount program.

2 "340B pharmacy" means any pharmacy used to dispense 340B
3 drugs for a covered entity, whether entity-owned or external.

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

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

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

16 (Source: P.A. 101-452, eff. 1-1-20; 102-558, eff. 8-20-21;
17 102-778, eff. 7-1-22.)

18 ARTICLE 110.

19 Section 110-5. The Specialized Mental Health
20 Rehabilitation Act of 2013 is amended by adding Section 5-113
21 as follows:

22 (210 ILCS 49/5-113 new)

23 Sec. 5-113. Specialized mental health rehabilitation

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

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

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

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

3 (305 ILCS 5/5-53 new)

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

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

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

19 ARTICLE 120.

20 (305 ILCS 5/15-6 rep.)

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

1 Article 125.

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

4 (30 ILCS 105/5.797)

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

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

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

10 (305 ILCS 5/12-10.6a)

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

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

20 (b) Disbursements from the Fund shall be made at the
21 direction of the Director of Healthcare and Family Services to
22 qualifying health care providers, in amounts established under

1 applicable federal regulation (42 CFR 495 et seq.), in order
2 to encourage the adoption and use of certified electronic
3 health records technology.

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

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

14 Article 130.

15 (30 ILCS 105/5.836 rep.)

16 Section 130-5. The State Finance Act is amended by
17 repealing Section 5.836.

18 (305 ILCS 5/5-31 rep.)

19 (305 ILCS 5/5-32 rep.)

20 Section 130-10. The Illinois Public Aid Code is amended by
21 repealing Sections 5-31 and 5-32.

22 Article 135.

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

3 (30 ILCS 105/5.481)

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

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

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

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

10 Sec. 12-9. Public Aid Recoveries Trust Fund; uses. The
11 Public Aid Recoveries Trust Fund shall consist of (1)
12 recoveries by the Department of Healthcare and Family Services
13 (formerly Illinois Department of Public Aid) authorized by
14 this Code in respect to applicants or recipients under
15 Articles III, IV, V, and VI, including recoveries made by the
16 Department of Healthcare and Family Services (formerly
17 Illinois Department of Public Aid) from the estates of
18 deceased recipients, (2) recoveries made by the Department of
19 Healthcare and Family Services (formerly Illinois Department
20 of Public Aid) in respect to applicants and recipients under
21 the Children's Health Insurance Program Act, and the Covering
22 ALL KIDS Health Insurance Act, (2.5) recoveries made by the

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

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

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

23 The balance in this Fund after payment therefrom of any
24 amounts reimbursable to the federal government, and minus the
25 amount ~~reasonably~~ anticipated to be needed to make the
26 disbursements authorized by this Section ~~during the current~~

1 ~~and following 3 calendar months,~~ shall be certified by the
2 Director of Healthcare and Family Services and transferred by
3 the State Comptroller to the Drug Rebate Fund or the
4 Healthcare Provider Relief Fund in the State Treasury, as
5 appropriate, on at least an annual basis by June 30th of each
6 fiscal year. The Director of Healthcare and Family Services
7 may certify and the State Comptroller shall transfer to the
8 Drug Rebate Fund or the Healthcare Provider Relief Fund
9 amounts on a more frequent basis.

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

14 (Source: P.A. 97-647, eff. 1-1-12; 97-689, eff. 6-14-12;
15 98-130, eff. 8-2-13; 98-651, eff. 6-16-14.)

16 (305 ILCS 5/12-10.4)

17 Sec. 12-10.4. Juvenile Rehabilitation Services Medicaid
18 Matching Fund. There is created in the State Treasury the
19 Juvenile Rehabilitation Services Medicaid Matching Fund.
20 Deposits to this Fund shall consist of all moneys received
21 from the federal government for behavioral health services
22 secured by counties pursuant to an agreement with the
23 Department of Healthcare and Family Services with respect to
24 Title XIX of the Social Security Act or under the Children's
25 Health Insurance Program pursuant to the Children's Health

1 Insurance Program Act and Title XXI of the Social Security Act
2 for minors who are committed to mental health facilities by
3 the Illinois court system and for residential placements
4 secured by the Department of Juvenile Justice for minors as a
5 condition of their aftercare release.

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

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

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

23 Article 140.

24 (30 ILCS 105/5.856 rep.)

1 Section 140-5. The State Finance Act is amended by
2 repealing Section 5.856.

3 (305 ILCS 5/Art. V-G rep.)

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

6 Article 145.

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

9 (30 ILCS 105/5.409)

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

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

13 (30 ILCS 105/6z-40)

14 Sec. 6z-40. Provider Inquiry Trust Fund. The Provider
15 Inquiry Trust Fund is created as a special fund in the State
16 treasury. Payments into the fund shall consist of fees or
17 other moneys owed by providers of services or their agents,
18 including other State agencies, for access to and utilization
19 of Illinois Department of Healthcare and Family Services
20 ~~Public Aid~~ eligibility files to verify eligibility of clients,
21 bills for services, or other similar, related uses.

1 Disbursements from the fund shall consist of payments to the
2 Department of Innovation and Technology ~~Central Management~~
3 ~~Services~~ for communication and statistical services and for
4 payments for administrative expenses incurred by the Illinois
5 Department of Healthcare and Family Services ~~Public Aid~~ in the
6 operation of the fund.

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

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

16 ARTICLE 150.

17 Section 150-5. The Illinois Public Aid Code is amended by
18 changing Section 5-30.1 and by adding Section 5-30.18 as
19 follows:

20 (305 ILCS 5/5-30.1)

21 Sec. 5-30.1. Managed care protections.

22 (a) As used in this Section:

23 "Managed care organization" or "MCO" means any entity

1 which contracts with the Department to provide services where
2 payment for medical services is made on a capitated basis.

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

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

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

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

18 ~~(4) emergency medical conditions, as defined by~~
19 ~~Section 10 of the Managed Care Reform and Patient Rights~~
20 ~~Act.~~

21 "Emergency medical condition" means a medical condition
22 manifesting itself by acute symptoms of sufficient severity,
23 regardless of the final diagnosis given, such that a prudent
24 layperson, who possesses an average knowledge of health and
25 medicine, could reasonably expect the absence of immediate
26 medical attention to result in:

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

4 (2) serious impairment to bodily functions;

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

6 (4) inadequately controlled pain; or

7 (5) with respect to a pregnant woman who is having
8 contractions:

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

11 (B) a transfer to another hospital may pose a
12 threat to the health or safety of the woman or unborn
13 child.

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

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

25 "Inpatient stabilization period" means the initial 72
26 hours of inpatient stabilization services, beginning from the

1 date and time of the order for inpatient admission to the
2 hospital.

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

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

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

20 "Service authorization determination" means a decision
21 made by a service authorization program in advance of,
22 concurrent to, or after the provision of a health care service
23 to approve, change the level of care, partially deny, deny, or
24 otherwise limit coverage and reimbursement for a health care
25 service upon review of a service authorization request.

26 "Service authorization program" means any utilization

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

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

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

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

22 (c) An MCO shall pay any provider of emergency services,
23 including for inpatient stabilization services provided during
24 the inpatient stabilization period, that does not have in
25 effect a contract with the contracted Medicaid MCO. The
26 default rate of reimbursement shall be the rate paid under

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

8 (d) (Blank). ~~An MCO shall pay for all post stabilization~~
9 ~~services as a covered service in any of the following~~
10 ~~situations:~~

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

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

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

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

19 ~~(5) the MCO and the treating provider, if the treating~~
20 ~~provider is a non-affiliated provider, could not reach an~~
21 ~~agreement concerning the enrollee's care and an affiliated~~
22 ~~provider was unavailable for a consultation, in which case~~
23 ~~the MCO must pay for such services rendered by the~~
24 ~~treating non-affiliated provider until an affiliated~~
25 ~~provider was reached and either concurred with the~~
26 ~~treating non-affiliated provider's plan of care or assumed~~

1 ~~responsibility for the enrollee's care. Such payment shall~~
2 ~~be made at the default rate of reimbursement paid under~~
3 ~~Illinois Medicaid fee for service program methodology,~~
4 ~~including all policy adjusters, including but not limited~~
5 ~~to Medicaid High Volume Adjustments, Medicaid Percentage~~
6 ~~Adjustments, Outpatient High Volume Adjustments and all~~
7 ~~outlier add on adjustments to the extent that such~~
8 ~~adjustments are incorporated in the development of the~~
9 ~~applicable MCO capitated rates.~~

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

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

20 (A) Notification period: Hospitals shall notify
21 the enrollee's Medicaid MCO within 48 hours of the
22 date and time the order for inpatient admission is
23 written. Notification shall be limited to advising the
24 MCO that the patient has been admitted to a hospital
25 inpatient level of care.

26 (B) If the admitting hospital complies with the

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

9 (C) Coverage for services provided during the
10 48-hour notification period may not be retrospectively
11 denied.

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

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

21 (4) The MCO shall not condition coverage for emergency
22 services on the treating provider notifying the MCO of the
23 enrollee's emergency medical screening examination and
24 treatment within 10 days after presentation for emergency
25 services.

26 (5) The determination of the attending emergency

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

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

19 (A) a plan physician with privileges at the
20 treating hospital assumes responsibility for the
21 enrollee's care;

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

24 (C) a contracting entity representative and the
25 treating physician reach an agreement concerning the
26 enrollee's care; or

1 (D) the enrollee is discharged.

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

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

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

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

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

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

1 Adjustments, and all outlier add-on adjustments to the
2 extent that such adjustments are incorporated in the
3 development of the applicable MCO capitated rates.

4 (f) Network adequacy and transparency.

5 (1) The Department shall:

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

9 (B) publicly release an explanation of its process
10 for analyzing network adequacy;

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

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

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

24 (F) require MCOs, including Medicaid Managed Care
25 Entities as defined in Section 5-30.2, to meet each of
26 the requirements under subsection (d-5) of Section 10

1 of the Network Adequacy and Transparency Act; with
2 necessary exceptions to the MCO's network to ensure
3 that admission and treatment with a provider or at a
4 treatment facility in accordance with the network
5 adequacy standards in paragraph (3) of subsection
6 (d-5) of Section 10 of the Network Adequacy and
7 Transparency Act is limited to providers or facilities
8 that are Medicaid certified.

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

18 (g) Timely payment of claims.

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

22 (2) The MCO shall notify the billing party of its
23 inability to adjudicate a claim within 30 days of
24 receiving that claim.

25 (3) The MCO shall pay a penalty that is at least equal
26 to the timely payment interest penalty imposed under

1 Section 368a of the Illinois Insurance Code for any claims
2 not timely paid.

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

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

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

20 (B) Compliance with the expedited provider requirement
21 may be satisfied by an MCO through the use of a Periodic
22 Interim Payment (PIP) program that has been mutually
23 agreed to and documented between the MCO and the provider,
24 if the PIP program ensures that any expedited provider
25 receives regular and periodic payments based on prior
26 period payment experience from that MCO. Total payments

1 under the PIP program may be reconciled against future PIP
2 payments on a schedule mutually agreed to between the MCO
3 and the provider.

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

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

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

20 (2) the Department shall, by December 31, 2016, adopt
21 rules establishing policies that shall be included in the
22 Medicaid managed care policy and procedures manual
23 addressing payment resolutions in situations in which a
24 provider renders services based upon information obtained
25 after verifying a patient's eligibility and coverage plan
26 through either the Department's current enrollment system

1 or a system operated by the coverage plan identified by
2 the patient presenting for services:

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

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

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

15 The rules on payment resolutions shall include, but
16 not be limited to:

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

18 (B) retroactive prior authorizations; and

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

24 The rules shall be applicable for both MCO coverage
25 and fee-for-service coverage.

26 If the fee-for-service system is ultimately determined to

1 have been responsible for coverage on the date of service, the
2 Department shall provide for an extended period for claims
3 submission outside the standard timely filing requirements.

4 (g-6) MCO Performance Metrics Report.

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

9 (A) claims payment, including timeliness and
10 accuracy;

11 (B) prior authorizations;

12 (C) grievance and appeals;

13 (D) utilization statistics;

14 (E) provider disputes;

15 (F) provider credentialing; and

16 (G) member and provider customer service.

17 (2) The Department shall ensure that the metrics
18 report is accessible to providers online by January 1,
19 2017.

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

25 (4) Metrics shall be defined and incorporated into the
26 applicable Managed Care Policy Manual issued by the

1 Department.

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

13 (g-8) Dispute resolution process. The Department shall
14 maintain a provider complaint portal through which a provider
15 can submit to the Department unresolved disputes with an MCO.
16 An unresolved dispute means an MCO's decision that denies in
17 whole or in part a claim for reimbursement to a provider for
18 health care services rendered by the provider to an enrollee
19 of the MCO with which the provider disagrees. Disputes shall
20 not be submitted to the portal until the provider has availed
21 itself of the MCO's internal dispute resolution process.
22 Disputes that are submitted to the MCO internal dispute
23 resolution process may be submitted to the Department of
24 Healthcare and Family Services' complaint portal no sooner
25 than 30 days after submitting to the MCO's internal process
26 and not later than 30 days after the unsatisfactory resolution

1 of the internal MCO process or 60 days after submitting the
2 dispute to the MCO internal process. Multiple claim disputes
3 involving the same MCO may be submitted in one complaint,
4 regardless of whether the claims are for different enrollees,
5 when the specific reason for non-payment of the claims
6 involves a common question of fact or policy. Within 10
7 business days of receipt of a complaint, the Department shall
8 present such disputes to the appropriate MCO, which shall then
9 have 30 days to issue its written proposal to resolve the
10 dispute. The Department may grant one 30-day extension of this
11 time frame to one of the parties to resolve the dispute. If the
12 dispute remains unresolved at the end of this time frame or the
13 provider is not satisfied with the MCO's written proposal to
14 resolve the dispute, the provider may, within 30 days, request
15 the Department to review the dispute and make a final
16 determination. Within 30 days of the request for Department
17 review of the dispute, both the provider and the MCO shall
18 present all relevant information to the Department for
19 resolution and make individuals with knowledge of the issues
20 available to the Department for further inquiry if needed.
21 Within 30 days of receiving the relevant information on the
22 dispute, or the lapse of the period for submitting such
23 information, the Department shall issue a written decision on
24 the dispute based on contractual terms between the provider
25 and the MCO, contractual terms between the MCO and the
26 Department of Healthcare and Family Services and applicable

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

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

11 (A) Premium revenue, with appropriate adjustments.

12 (B) Benefit expense, setting forth the aggregate
13 amount spent for the following:

14 (i) Direct paid claims.

15 (ii) Subcapitation payments.

16 (iii) Other claim payments.

17 (iv) Direct reserves.

18 (v) Gross recoveries.

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

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

24 (g-10) (1) "Liability effective date" means the date on
25 which an MCO becomes responsible for payment for medically
26 necessary and covered services rendered by a provider to one

1 of its enrollees in accordance with the contract terms between
2 the MCO and the provider. The liability effective date shall
3 be the later of:

4 (A) The execution date of a network participation
5 contract agreement.

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

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

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

17 (3) By October 1, 2019, the Department shall require all
18 MCOs to update their provider directory with information for
19 new practitioners of existing contracted providers within 30
20 days of receipt of a complete and accurate standardized roster
21 template in the format approved by the Department provided
22 that the provider is effective in the Department's provider
23 enrollment subsystem within the IMPACT system. Such provider
24 directory shall be readily accessible for purposes of
25 selecting an approved health care provider and comply with all
26 other federal and State requirements.

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

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

20 Under no circumstances, either by an MCO or under the
21 State's fee-for-service system, shall a provider be denied
22 payment for failure to comply with any timely submission
23 requirements under this Code or under any existing contract,
24 unless the non-electronic format claim submission occurs after
25 the initial 180 days following the latest date of service on
26 the claim, or after the 90 business days correction period

1 following notification to the provider of rejection or denial
2 of payment.

3 (g-13) Utilization Review Standardization and
4 Transparency.

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

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

21 (A) guidelines related to the publication of MCO
22 authorization policies;

23 (B) procedures that, due to medical complexity,
24 must be reimbursed under the applicable inpatient
25 methodology, when provided in the inpatient setting
26 and billed as an inpatient service;

1 (C) standardization of administrative forms used
2 in the member appeal process;

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

7 (E) standardization of peer-to-peer processes and
8 timelines;

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

11 (G) standardized criteria for service
12 authorization programs for authorization of admission
13 to a long-term acute care hospital.

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

18 (A) an analysis of the Medicaid MCO's compliance
19 with nationally recognized clinical decision
20 guidelines;

21 (B) an analysis that compares and contrasts the
22 Medicaid MCO's service authorization determination
23 outcomes to the outcomes of each other MCO plan and the
24 State's fee-for-service program model to evaluate
25 whether service authorization determinations are being
26 made consistently by all Medicaid MCOs to ensure that

1 all individuals are being treated in accordance with
2 equitable standards of care;

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

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

22 (h) The Department shall not expand mandatory MCO
23 enrollment into new counties beyond those counties already
24 designated by the Department as of June 1, 2014 for the
25 individuals whose eligibility for medical assistance is not
26 the seniors or people with disabilities population until the

1 Department provides an opportunity for accountable care
2 entities and MCOs to participate in such newly designated
3 counties.

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

21 (i) The requirements of this Section apply to contracts
22 with accountable care entities and MCOs entered into, amended,
23 or renewed after June 16, 2014 (the effective date of Public
24 Act 98-651).

25 (j) Health care information released to managed care
26 organizations. A health care provider shall release to a

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

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

14 (l) The requirements of this Section added by Public Act
15 102-4 shall apply to services provided on or after the first
16 day of the month that begins 60 days after April 27, 2021 (the
17 effective date of Public Act 102-4).

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

22 (Source: P.A. 102-4, eff. 4-27-21; 102-43, eff. 7-6-21;
23 102-144, eff. 1-1-22; 102-454, eff. 8-20-21; 102-813, eff.
24 5-13-22; 103-546, eff. 8-11-23.)

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

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

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

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

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

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

25 "Service authorization program" means any utilization
26 review, utilization management, peer review, quality review,

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

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

16 "Utilization review organization" or "URO" means a managed
17 care organization or other entity that has established or
18 administers one or more service authorization programs.

19 (b) In consultation with the Medicaid MCOs, a statewide
20 association representing managed care organizations, a
21 statewide association representing the majority of Illinois
22 hospitals, and a statewide association representing
23 physicians, the Department shall in accordance with the
24 Illinois Administrative Procedure Act, adopt administrative
25 rules, consistent with this Section, to require each Medicaid
26 MCO to identify Gold Card providers with such identification

1 initially being effective for health care services provided on
2 and after July 1, 2025.

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

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

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

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

25 (4) The provider shall be required to continue to
26 document medically necessary, clinically appropriate care

1 and submit such documentation to the Medicaid MCO for the
2 purpose of continuous performance monitoring. If a
3 provider fails to maintain the 90% service authorization
4 standard, as determined on no more frequent a basis than
5 bi-annually, the provider's service authorization
6 exemption is subject to temporary or permanent suspension.

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

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

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

25 (8) Require each Medicaid MCO to provide the
26 Department a list of all providers who were denied a

1 service authorization exemption or had a previously
2 granted service authorization exemption suspended, with
3 such denials being subject to an annual audit conducted by
4 an independent third-party URO to ensure their
5 appropriateness.

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

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

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

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

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

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

4 (210 ILCS 135/13.3 new)

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

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

1 diem reimbursement shall be in addition to the existing
2 occupancy factor policy set by the Division of Developmental
3 Disabilities.

4 ARTICLE 160.

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

7 (305 ILCS 5/5-5.12f new)

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

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

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

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

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

19 (b) The following safety edits shall be permitted for
20 prescription drugs covered under this Section:

21 (1) clinically appropriate drug utilization review
22 (DUR) edits, including, but not limited to, drug-to-drug,
23 drug-age, and drug-dose;

24 (2) generic drug substitution if a generic drug is
25 available for the prescribed medication in the same dosage
26 and formulation; and

1 (3) any utilization management control that is
2 necessary for the Department to comply with any current
3 consent decrees or federal waivers.

4 (c) As used in this Section, "serious mental illness"
5 means any one or more of the following diagnoses and
6 International Classification of Diseases, Tenth Revision,
7 Clinical Modification (ICD-10-CM) codes listed by the
8 Department of Human Services' Division of Mental Health, as
9 amended, on its official website:

10 (1) Delusional Disorder (F22)

11 (2) Brief Psychotic Disorder (F23)

12 (3) Schizophreniform Disorder (F20.81)

13 (4) Schizophrenia (F20.9)

14 (5) Schizoaffective Disorder (F25.x)

15 (6) Catatonia Associated with Another Mental Disorder
16 (Catatonia Specifier) (F06.1)

17 (7) Other Specified Schizophrenia Spectrum and Other
18 Psychotic Disorder (F28)

19 (8) Unspecified Schizophrenia Spectrum and Other
20 Psychotic Disorder (F29)

21 (9) Bipolar I Disorder (F31.xx)

22 (10) Bipolar II Disorder (F31.81)

23 (11) Cyclothymic Disorder (F34.0)

24 (12) Unspecified Bipolar and Related Disorder (F31.9)

25 (13) Disruptive Mood Dysregulation Disorder (F34.8)

26 (14) Major Depressive Disorder Single episode (F32.xx)

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

25 (c) The Department may adopt rules to implement this
26 Section. Rules that establish or modify the services,

1 standards, and conditions for participation in the program
2 shall be adopted by the Department in consultation with the
3 Department on Aging, the Department of Rehabilitation
4 Services, and the Department of Mental Health and
5 Developmental Disabilities (or their successor agencies).

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

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

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

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

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

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

6 (f) Section 9817 of the American Rescue Plan Act of 2021
7 (Public Law 117-2) authorizes a 10% enhanced federal medical
8 assistance percentage for supportive living services for a
9 12-month period from April 1, 2021 through March 31, 2022.
10 Subject to federal approval, including the approval of any
11 necessary waiver amendments or other federally required
12 documents or assurances, for a 12-month period the Department
13 must pay a supplemental \$26 per diem rate to all supportive
14 living facilities with the additional federal financial
15 participation funds that result from the enhanced federal
16 medical assistance percentage from April 1, 2021 through March
17 31, 2022. The Department may issue parameters around how the
18 supplemental payment should be spent, including quality
19 improvement activities. The Department may alter the form,
20 methods, or timeframes concerning the supplemental per diem
21 rate to comply with any subsequent changes to federal law,
22 changes made by guidance issued by the federal Centers for
23 Medicare and Medicaid Services, or other changes necessary to
24 receive the enhanced federal medical assistance percentage.

25 (g) All applications for the expansion of supportive
26 living dementia care settings involving sites not approved by

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

14 (h) As stated in the supportive living program home and
15 community-based service waiver approved by the federal Centers
16 for Medicare and Medicaid Services, and beginning July 1,
17 2025, the Department must maintain the rate add-on implemented
18 on January 1, 2023 for the provision of 2 meals per day at no
19 less than \$6.15 per day.

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

23 ARTICLE 170.

24 Section 170-5. The Illinois Public Aid Code is amended by

1 adding Section 5-2.06a as follows:

2 (305 ILCS 5/5-2.06a new)

3 Sec. 5-2.06a. Medically fragile children; reimbursement
4 for legally responsible family caregivers. By January 1, 2025,
5 the Department of Healthcare and Family Services shall apply
6 for a Home and Community-Based Services State Plan amendment
7 and any federal waiver necessary to reimburse legally
8 responsible family caregivers as providers of personal care or
9 home health aide services under the Illinois Title XIX State
10 Plan Home and Community-Based Services benefit and the home
11 and community-based services waiver program authorized under
12 Section 1915(c) of the Social Security Act for persons who are
13 medically fragile and technology dependent. To be eligible for
14 reimbursement under this Section, a legally responsible family
15 caregiver must be a certified nursing assistant or certified
16 nurse aide and must provide services to a medically fragile
17 relative who is receiving in-home shift nursing services
18 coordinated by the University of Illinois at Chicago, Division
19 of Specialized Care for Children. Upon federal approval of the
20 State Plan amendment and waiver, the Department shall
21 promulgate rules that define who qualifies for reimbursement
22 as a legally responsible family caregiver, specify which
23 personal care and home health aide services are eligible for
24 reimbursement if the provider is a legally responsible family
25 caregiver, establish oversight policies to ensure legally

1 responsible family caregivers meet and comply with licensing
2 and program requirements, and adopt any other policies or
3 procedures necessary to implement this Section.

4 ARTICLE 175.

5 Section 175-5. The Illinois Public Aid Code is amended by
6 changing Section 5-5.5 as follows:

7 (305 ILCS 5/5-5.5) (from Ch. 23, par. 5-5.5)

8 Sec. 5-5.5. Elements of Payment Rate.

9 (a) The Department of Healthcare and Family Services shall
10 develop a prospective method for determining payment rates for
11 nursing facility and ICF/DD services in nursing facilities
12 composed of the following cost elements:

13 (1) Standard Services, with the cost of this component
14 being determined by taking into account the actual costs
15 to the facilities of these services subject to cost
16 ceilings to be defined in the Department's rules.

17 (2) Resident Services, with the cost of this component
18 being determined by taking into account the actual costs,
19 needs and utilization of these services, as derived from
20 an assessment of the resident needs in the nursing
21 facilities.

22 (3) Ancillary Services, with the payment rate being
23 developed for each individual type of service. Payment

1 shall be made only when authorized under procedures
2 developed by the Department of Healthcare and Family
3 Services.

4 (4) Nurse's Aide Training, with the cost of this
5 component being determined by taking into account the
6 actual cost to the facilities of such training.

7 (5) Real Estate Taxes, with the cost of this component
8 being determined by taking into account the figures
9 contained in the most currently available cost reports
10 (with no imposition of maximums) updated to the midpoint
11 of the current rate year for long term care services
12 rendered between July 1, 1984 and June 30, 1985, and with
13 the cost of this component being determined by taking into
14 account the actual 1983 taxes for which the nursing homes
15 were assessed (with no imposition of maximums) updated to
16 the midpoint of the current rate year for long term care
17 services rendered between July 1, 1985 and June 30, 1986.

18 (b) In developing a prospective method for determining
19 payment rates for nursing facility and ICF/DD services in
20 nursing facilities and ICF/DDs, the Department of Healthcare
21 and Family Services shall consider the following cost
22 elements:

23 (1) Reasonable capital cost determined by utilizing
24 incurred interest rate and the current value of the
25 investment, including land, utilizing composite rates, or
26 by utilizing such other reasonable cost related methods

1 determined by the Department. However, beginning with the
2 rate reimbursement period effective July 1, 1987, the
3 Department shall be prohibited from establishing,
4 including, and implementing any depreciation factor in
5 calculating the capital cost element.

6 (2) Profit, with the actual amount being produced and
7 accruing to the providers in the form of a return on their
8 total investment, on the basis of their ability to
9 economically and efficiently deliver a type of service.
10 The method of payment may assure the opportunity for a
11 profit, but shall not guarantee or establish a specific
12 amount as a cost.

13 (c) The Illinois Department may implement the amendatory
14 changes to this Section made by this amendatory Act of 1991
15 through the use of emergency rules in accordance with the
16 provisions of Section 5.02 of the Illinois Administrative
17 Procedure Act. For purposes of the Illinois Administrative
18 Procedure Act, the adoption of rules to implement the
19 amendatory changes to this Section made by this amendatory Act
20 of 1991 shall be deemed an emergency and necessary for the
21 public interest, safety and welfare.

22 (d) No later than January 1, 2001, the Department of
23 Public Aid shall file with the Joint Committee on
24 Administrative Rules, pursuant to the Illinois Administrative
25 Procedure Act, a proposed rule, or a proposed amendment to an
26 existing rule, regarding payment for appropriate services,

1 including assessment, care planning, discharge planning, and
2 treatment provided by nursing facilities to residents who have
3 a serious mental illness.

4 (e) 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 (f) Beginning January 1, 2025, the real estate tax
10 component of the payment rate shall be updated using the most
11 recent property tax bill on file with the Department for
12 facilities licensed under the Nursing Home Care Act and
13 facilities licensed under the Specialized Mental Health
14 Rehabilitation Act of 2013. The per diem rate shall be
15 computed by dividing the real estate tax costs reported in the
16 cost report inflated to the midpoint of the rate year by the
17 total number of patient days reported in the same cost report.
18 Computation of the real estate tax component shall be based on
19 capital days.

20 (Source: P.A. 96-1123, eff. 1-1-11; 96-1530, eff. 2-16-11;
21 97-689, eff. 6-14-12.)

22 ARTICLE 180.

23 Section 180-5. The Illinois Public Aid Code is amended by
24 changing Section 5-5.2 as follows:

1 (305 ILCS 5/5-5.2)

2 Sec. 5-5.2. Payment.

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

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

9 (c) (Blank).

10 (c-1) Notwithstanding any other provisions of this Code,
11 the methodologies for reimbursement of nursing services as
12 provided under this Article shall no longer be applicable for
13 bills payable for nursing services rendered on or after a new
14 reimbursement system based on the Patient Driven Payment Model
15 (PDPM) has been fully operationalized, which shall take effect
16 for services provided on or after the implementation of the
17 PDPM reimbursement system begins. For the purposes of Public
18 Act 102-1035 ~~this amendatory Act of the 102nd General~~
19 ~~Assembly~~, the implementation date of the PDPM reimbursement
20 system and all related provisions shall be July 1, 2022 if the
21 following conditions are met: (i) the Centers for Medicare and
22 Medicaid Services has approved corresponding changes in the
23 reimbursement system and bed assessment; and (ii) the
24 Department has filed rules to implement these changes no later
25 than June 1, 2022. Failure of the Department to file rules to

1 implement the changes provided in Public Act 102-1035 ~~this~~
2 ~~amendatory Act of the 102nd General Assembly~~ no later than
3 June 1, 2022 shall result in the implementation date being
4 delayed to October 1, 2022.

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

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

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

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

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

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

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

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

20 Beginning October 1, 2024, the staffing percentage
21 used in the calculation of the per diem staffing add-on
22 shall be its PDPM STRIVE Staffing Ratio which equals: its
23 Reported Total Nurse Staffing Hours Per Resident Per Day
24 as published in the most recent federal staffing report
25 (the Provider Information File), divided by the facility's
26 PDPM STRIVE Staffing Target. Each facility's PDPM STRIVE

1 Staffing Target is equal to .82 times the facility's
2 Illinois Adjusted Facility Case-Mix Hours Per Resident Per
3 Day. A facility's Illinois Adjusted Facility Case Mix
4 Hours Per Resident Per Day is equal to its Case-Mix Total
5 Nurse Staffing Hours Per Resident Per Day (as published in
6 the most recent federal staffing report) times 3.662
7 (which reflects the national resident days-weighted mean
8 Reported Total Nurse Staffing Hours Per Resident Per Day
9 as calculated using the January 2024 federal Provider
10 Information Files), divided by the national resident
11 days-weighted mean Reported Total Nurse Staffing Hours Per
12 Resident Per Day calculated using the most recent federal
13 Provider Information File.

14 (6.5) Beginning July 1, 2024, the paid per diem
15 staffing add-on shall be the paid per diem staffing add-on
16 in effect April 1, 2024. For dates beginning October 1,
17 2024 and through September 30, 2025, the denominator for
18 the staffing percentage shall be the lesser of the
19 facility's PDPM STRIVE Staffing Target and:

20 (A) For the quarter beginning October 1, 2024, the
21 sum of 20% of the facility's PDPM STRIVE Staffing
22 Target and 80% of the facility's Case-Mix Total Nurse
23 Staffing Hours Per Resident Per Day (as published in
24 the January 2024 federal staffing report).

25 (B) For the quarter beginning January 1, 2025, the
26 sum of 40% of the facility's PDPM STRIVE Staffing

1 Target and 60% of the facility's Case-Mix Total Nurse
2 Staffing Hours Per Resident Per Day (as published in
3 the January 2024 federal staffing report).

4 (C) For the quarter beginning March 1, 2025, the
5 sum of 60% of the facility's PDPM STRIVE Staffing
6 Target and 40% of the facility's Case-Mix Total Nurse
7 Staffing Hours Per Resident Per Day (as published in
8 the January 2024 federal staffing report).

9 (D) For the quarter beginning July 1, 2025, the
10 sum of 80% of the facility's PDPM STRIVE Staffing
11 Target and 20% of the facility's Case-Mix Total Nurse
12 Staffing Hours Per Resident Per Day (as published in
13 the January 2024 federal staffing report).

14 Facilities with at least 70% of the staffing
15 indicated by the STRIVE study shall be paid a per diem
16 add-on of \$9, increasing by equivalent steps for each
17 whole percentage point until the facilities reach a per
18 diem of \$16.52 ~~\$14.88~~. Facilities with at least 80% of the
19 staffing indicated by the STRIVE study shall be paid a per
20 diem add-on of \$16.52 ~~\$14.88~~, increasing by equivalent
21 steps for each whole percentage point until the facilities
22 reach a per diem add-on of \$25.77 ~~\$23.80~~. Facilities with
23 at least 92% of the staffing indicated by the STRIVE study
24 shall be paid a per diem add-on of \$25.77 ~~\$23.80~~,
25 increasing by equivalent steps for each whole percentage
26 point until the facilities reach a per diem add-on of

1 \$30.98 ~~\$29.75~~. Facilities with at least 100% of the
2 staffing indicated by the STRIVE study shall be paid a per
3 diem add-on of \$30.98 ~~\$29.75~~, increasing by equivalent
4 steps for each whole percentage point until the facilities
5 reach a per diem add-on of \$36.44 ~~\$35.70~~. Facilities with
6 at least 110% of the staffing indicated by the STRIVE
7 study shall be paid a per diem add-on of \$36.44 ~~\$35.70~~,
8 increasing by equivalent steps for each whole percentage
9 point until the facilities reach a per diem add-on of
10 \$38.68. Facilities with at least 125% or higher of the
11 staffing indicated by the STRIVE study shall be paid a per
12 diem add-on of \$38.68. ~~No Beginning April 1, 2023, no~~
13 nursing facility's variable staffing per diem add-on shall
14 be reduced by more than 5% in 2 consecutive quarters. For
15 the quarters beginning July 1, 2022 and October 1, 2022,
16 no facility's variable per diem staffing add-on shall be
17 calculated at a rate lower than 85% of the staffing
18 indicated by the STRIVE study. No facility below 70% of
19 the staffing indicated by the STRIVE study shall receive a
20 variable per diem staffing add-on after December 31, 2022.

21 (7) For dates of services beginning July 1, 2022, the
22 PDPM nursing component per diem for each nursing facility
23 shall be the product of the facility's (i) statewide PDPM
24 nursing base per diem rate, \$92.25, adjusted for the
25 facility average PDPM case mix index calculated quarterly
26 and (ii) the regional wage adjuster, and then add the

1 Medicaid access adjustment as defined in (e-3) of this
2 Section. Transition rates for services provided between
3 July 1, 2022 and October 1, 2023 shall be the greater of
4 the PDPM nursing component per diem or:

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

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

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

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

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

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

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

3 (1) Base rate spending pool shall be:

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

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

11 (C) Thirteen million is added to the product of
12 subparagraph (A) and subparagraph (B) to adjust for
13 the exclusion of nursing homes defined in paragraph
14 (5).

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

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

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

25 (C) Facility weighted case mix which is the number
26 of Medicaid residents as indicated by the MDS data

1 defined in paragraph (4) multiplied by the associated
2 case weight for the RUG-IV 48 grouper model using
3 standard RUG-IV procedures for index maximization.

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

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

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

12 (B) on and after July 1, 2014 and until July 1,
13 2022, shall be the amount calculated under
14 subparagraph (A) of this paragraph (3) plus \$1.76; and

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

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

22 (5) Nursing facilities designated as of July 1, 2012
23 by the Department as "Institutions for Mental Disease"
24 shall be excluded from all calculations under this
25 subsection. The data from these facilities shall not be
26 used in the computations described in paragraphs (1)

1 through (4) above to establish the base rate.

2 (e) Beginning July 1, 2014, the Department shall allocate
3 funding in the amount up to \$10,000,000 for per diem add-ons to
4 the RUGS methodology for dates of service on and after July 1,
5 2014:

6 (1) \$0.63 for each resident who scores in I4200
7 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

8 (2) \$2.67 for each resident who scores either a "1" or
9 "2" in any items S1200A through S1200I and also scores in
10 RUG groups PA1, PA2, BA1, or BA2.

11 (e-1) (Blank).

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

20 (e-3) A Medicaid Access Adjustment of \$4 adjusted for the
21 facility average PDPM case mix index calculated quarterly
22 shall be added to the statewide PDPM nursing per diem for all
23 facilities with annual Medicaid bed days of at least 70% of all
24 occupied bed days adjusted quarterly. For each new calendar
25 year and for the 6-month period beginning July 1, 2022, the
26 percentage of a facility's occupied bed days comprised of

1 Medicaid bed days shall be determined by the Department
2 quarterly. For dates of service beginning January 1, 2023, the
3 Medicaid Access Adjustment shall be increased to \$4.75. This
4 subsection shall be inoperative on and after January 1, 2028.

5 (e-4) Subject to federal approval, on and after January 1,
6 2024, the Department shall increase the rate add-on at
7 paragraph (7) subsection (a) under 89 Ill. Adm. Code 147.335
8 for ventilator services from \$208 per day to \$481 per day.
9 Payment is subject to the criteria and requirements under 89
10 Ill. Adm. Code 147.335.

11 (f) (Blank).

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

17 (1) (Blank);

18 (2) (Blank);

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

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

1 socio-developmental, capital, and support components of their
2 reimbursement rate effective May 1, 2011 reduced in total by
3 2.7%.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (C) Each nursing home's quality weight score is
26 divided by the sum of all quality weight scores for

1 qualifying nursing homes to determine the proportion
2 of the quality pool to be paid to the nursing home.

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

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

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

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

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

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

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

25 (Source: P.A. 102-77, eff. 7-9-21; 102-558, eff. 8-20-21;
26 102-1035, eff. 5-31-22; 102-1118, eff. 1-18-23; 103-102,

1 Article 40, Section 40-5, eff. 1-1-24; 103-102, Article 50,
2 Section 50-5, eff. 1-1-24; revised 12-15-23.)

3 ARTICLE 185.

4 Section 185-5. The Illinois Public Aid Code is amended by
5 changing Section 5-5a.1 as follows:

6 (305 ILCS 5/5-5a.1)

7 Sec. 5-5a.1. Telehealth services for persons with
8 intellectual and developmental disabilities. The Department
9 shall file an amendment to the Home and Community-Based
10 Services Waiver Program for Adults with Developmental
11 Disabilities authorized under Section 1915(c) of the Social
12 Security Act to incorporate telehealth services administered
13 by a provider of telehealth services that demonstrates
14 knowledge and experience in providing medical and emergency
15 services for persons with intellectual and developmental
16 disabilities. For dates of service on and after January 1,
17 2025, the Department shall pay negotiated, agreed upon
18 administrative fees associated with implementing telehealth
19 services for persons with intellectual and developmental
20 disabilities who are receiving Community Integrated Living
21 Arrangement residential services under the Home and
22 Community-Based Services Waiver Program for Adults with
23 Developmental Disabilities. The implementation of telehealth

1 services shall not impede the choice of any individual
2 receiving waiver-funded services through the Home and
3 Community-Based Services Waiver Program for Adults with
4 Developmental Disabilities to receive in-person health care
5 services at any time. The Department shall ensure individuals
6 enrolled in the waiver, or their guardians, request to opt-in
7 to these services. For individuals who opt in, this service
8 shall be included in the individual's person-centered plan.
9 The use of telehealth services shall not be used for the
10 convenience of staff at any time nor shall it replace primary
11 care physician services. ~~The Department shall pay~~
12 ~~administrative fees associated with implementing telehealth~~
13 ~~services for all persons with intellectual and developmental~~
14 ~~disabilities who are receiving services under the Home and~~
15 ~~Community Based Services Waiver Program for Adults with~~
16 ~~Developmental Disabilities.~~

17 (Source: P.A. 103-102, eff. 7-1-23.)

18 ARTICLE 190.

19 Section 190-5. The Pharmacy Practice Act is amended by
20 changing Sections 3 and 9.6 as follows:

21 (225 ILCS 85/3)

22 (Section scheduled to be repealed on January 1, 2028)

23 Sec. 3. Definitions. For the purpose of this Act, except

1 where otherwise limited therein:

2 (a) "Pharmacy" or "drugstore" means and includes every
3 store, shop, pharmacy department, or other place where
4 pharmacist care is provided by a pharmacist (1) where drugs,
5 medicines, or poisons are dispensed, sold or offered for sale
6 at retail, or displayed for sale at retail; or (2) where
7 prescriptions of physicians, dentists, advanced practice
8 registered nurses, physician assistants, veterinarians,
9 podiatric physicians, or optometrists, within the limits of
10 their licenses, are compounded, filled, or dispensed; or (3)
11 which has upon it or displayed within it, or affixed to or used
12 in connection with it, a sign bearing the word or words
13 "Pharmacist", "Druggist", "Pharmacy", "Pharmaceutical Care",
14 "Apothecary", "Drugstore", "Medicine Store", "Prescriptions",
15 "Drugs", "Dispensary", "Medicines", or any word or words of
16 similar or like import, either in the English language or any
17 other language; or (4) where the characteristic prescription
18 sign (Rx) or similar design is exhibited; or (5) any store, or
19 shop, or other place with respect to which any of the above
20 words, objects, signs or designs are used in any
21 advertisement.

22 (b) "Drugs" means and includes (1) articles recognized in
23 the official United States Pharmacopoeia/National Formulary
24 (USP/NF), or any supplement thereto and being intended for and
25 having for their main use the diagnosis, cure, mitigation,
26 treatment or prevention of disease in man or other animals, as

1 approved by the United States Food and Drug Administration,
2 but does not include devices or their components, parts, or
3 accessories; and (2) all other articles intended for and
4 having for their main use the diagnosis, cure, mitigation,
5 treatment or prevention of disease in man or other animals, as
6 approved by the United States Food and Drug Administration,
7 but does not include devices or their components, parts, or
8 accessories; and (3) articles (other than food) having for
9 their main use and intended to affect the structure or any
10 function of the body of man or other animals; and (4) articles
11 having for their main use and intended for use as a component
12 or any articles specified in clause (1), (2) or (3); but does
13 not include devices or their components, parts or accessories.

14 (c) "Medicines" means and includes all drugs intended for
15 human or veterinary use approved by the United States Food and
16 Drug Administration.

17 (d) "Practice of pharmacy" means:

18 (1) the interpretation and the provision of assistance
19 in the monitoring, evaluation, and implementation of
20 prescription drug orders;

21 (2) the dispensing of prescription drug orders;

22 (3) participation in drug and device selection;

23 (4) drug administration limited to the administration
24 of oral, topical, injectable, and inhalation as follows:

25 (A) in the context of patient education on the
26 proper use or delivery of medications;

1 (B) vaccination of patients 7 years of age and
2 older pursuant to a valid prescription or standing
3 order, by a physician licensed to practice medicine in
4 all its branches, except for vaccinations covered by
5 paragraph (15), upon completion of appropriate
6 training, including how to address contraindications
7 and adverse reactions set forth by rule, with
8 notification to the patient's physician and
9 appropriate record retention, or pursuant to hospital
10 pharmacy and therapeutics committee policies and
11 procedures. Eligible vaccines are those listed on the
12 U.S. Centers for Disease Control and Prevention (CDC)
13 Recommended Immunization Schedule, the CDC's Health
14 Information for International Travel, or the U.S. Food
15 and Drug Administration's Vaccines Licensed and
16 Authorized for Use in the United States. As applicable
17 to the State's Medicaid program and other payers,
18 vaccines ordered and administered in accordance with
19 this subsection shall be covered and reimbursed at no
20 less than the rate that the vaccine is reimbursed when
21 ordered and administered by a physician;

22 (B-5) following the initial administration of
23 long-acting or extended-release form opioid
24 antagonists by a physician licensed to practice
25 medicine in all its branches, administration of
26 injections of long-acting or extended-release form

1 opioid antagonists for the treatment of substance use
2 disorder, pursuant to a valid prescription by a
3 physician licensed to practice medicine in all its
4 branches, upon completion of appropriate training,
5 including how to address contraindications and adverse
6 reactions, including, but not limited to, respiratory
7 depression and the performance of cardiopulmonary
8 resuscitation, set forth by rule, with notification to
9 the patient's physician and appropriate record
10 retention, or pursuant to hospital pharmacy and
11 therapeutics committee policies and procedures;

12 (C) administration of injections of
13 alpha-hydroxyprogesterone caproate, pursuant to a
14 valid prescription, by a physician licensed to
15 practice medicine in all its branches, upon completion
16 of appropriate training, including how to address
17 contraindications and adverse reactions set forth by
18 rule, with notification to the patient's physician and
19 appropriate record retention, or pursuant to hospital
20 pharmacy and therapeutics committee policies and
21 procedures; and

22 (D) administration of injections of long-term
23 antipsychotic medications pursuant to a valid
24 prescription by a physician licensed to practice
25 medicine in all its branches, upon completion of
26 appropriate training conducted by an Accreditation

1 Council of Pharmaceutical Education accredited
2 provider, including how to address contraindications
3 and adverse reactions set forth by rule, with
4 notification to the patient's physician and
5 appropriate record retention, or pursuant to hospital
6 pharmacy and therapeutics committee policies and
7 procedures.

8 (5) (blank);

9 (6) drug regimen review;

10 (7) drug or drug-related research;

11 (8) the provision of patient counseling;

12 (9) the practice of telepharmacy;

13 (10) the provision of those acts or services necessary
14 to provide pharmacist care;

15 (11) medication therapy management;

16 (12) the responsibility for compounding and labeling
17 of drugs and devices (except labeling by a manufacturer,
18 repackager, or distributor of non-prescription drugs and
19 commercially packaged legend drugs and devices), proper
20 and safe storage of drugs and devices, and maintenance of
21 required records;

22 (13) the assessment and consultation of patients and
23 dispensing of hormonal contraceptives;

24 (14) the initiation, dispensing, or administration of
25 drugs, laboratory tests, assessments, referrals, and
26 consultations for human immunodeficiency virus

1 pre-exposure prophylaxis and human immunodeficiency virus
2 post-exposure prophylaxis under Section 43.5;

3 (15) vaccination of patients 7 years of age and older
4 for COVID-19 or influenza subcutaneously, intramuscularly,
5 or orally as authorized, approved, or licensed by the
6 United States Food and Drug Administration, pursuant to
7 the following conditions:

8 (A) the vaccine must be authorized or licensed by
9 the United States Food and Drug Administration;

10 (B) the vaccine must be ordered and administered
11 according to the Advisory Committee on Immunization
12 Practices standard immunization schedule;

13 (C) the pharmacist must complete a course of
14 training accredited by the Accreditation Council on
15 Pharmacy Education or a similar health authority or
16 professional body approved by the Division of
17 Professional Regulation;

18 (D) the pharmacist must have a current certificate
19 in basic cardiopulmonary resuscitation;

20 (E) the pharmacist must complete, during each
21 State licensing period, a minimum of 2 hours of
22 immunization-related continuing pharmacy education
23 approved by the Accreditation Council on Pharmacy
24 Education;

25 (F) the pharmacist must comply with recordkeeping
26 and reporting requirements of the jurisdiction in

1 which the pharmacist administers vaccines, including
2 informing the patient's primary-care provider, when
3 available, and complying with requirements whereby the
4 person administering a vaccine must review the vaccine
5 registry or other vaccination records prior to
6 administering the vaccine; and

7 (G) the pharmacist must inform the pharmacist's
8 patients who are less than 18 years old, as well as the
9 adult caregiver accompanying the child, of the
10 importance of a well-child visit with a pediatrician
11 or other licensed primary-care provider and must refer
12 patients as appropriate;

13 (16) the ordering and administration of COVID-19
14 therapeutics subcutaneously, intramuscularly, or orally
15 with notification to the patient's physician and
16 appropriate record retention or pursuant to hospital
17 pharmacy and therapeutics committee policies and
18 procedures. Eligible therapeutics are those approved,
19 authorized, or licensed by the United States Food and Drug
20 Administration and must be administered subcutaneously,
21 intramuscularly, or orally in accordance with that
22 approval, authorization, or licensing; and

23 (17) the ordering and administration of point of care
24 tests, ~~and~~ screenings, and treatments for (i) influenza,
25 (ii) SARS-CoV-2 ~~SARS COV-2~~, (iii) Group A Streptococcus,
26 (iv) respiratory syncytial virus, (v) adult-stage head

1 louse, and (vi) ~~(iii)~~ health conditions identified by a
2 statewide public health emergency, as defined in the
3 Illinois Emergency Management Agency Act, with
4 notification to the patient's physician, if any, and
5 appropriate record retention or pursuant to hospital
6 pharmacy and therapeutics committee policies and
7 procedures. Eligible tests and screenings are those
8 approved, authorized, or licensed by the United States
9 Food and Drug Administration and must be administered in
10 accordance with that approval, authorization, or
11 licensing.

12 A pharmacist who orders or administers tests or
13 screenings for health conditions described in this
14 paragraph may use a test that may guide clinical
15 decision-making for the health condition that is waived
16 under the federal Clinical Laboratory Improvement
17 Amendments of 1988 and regulations promulgated thereunder
18 or any established screening procedure that is established
19 under a statewide protocol.

20 A pharmacist may delegate the administrative and
21 technical tasks of performing a test for the health
22 conditions described in this paragraph to a registered
23 pharmacy technician or student pharmacist acting under the
24 supervision of the pharmacist.

25 The testing, screening, and treatment ordered under
26 this paragraph by a pharmacist shall not be denied

1 reimbursement under health benefit plans that are within
2 the scope of the pharmacist's license and shall be covered
3 as if the services or procedures were performed by a
4 physician, an advanced practice registered nurse, or a
5 physician assistant.

6 A pharmacy benefit manager, health carrier, health
7 benefit plan, or third-party payor shall not discriminate
8 against a pharmacy or a pharmacist with respect to
9 participation referral, reimbursement of a covered
10 service, or indemnification if a pharmacist is acting
11 within the scope of the pharmacist's license and the
12 pharmacy is operating in compliance with all applicable
13 laws and rules.

14 A pharmacist who performs any of the acts defined as the
15 practice of pharmacy in this State must be actively licensed
16 as a pharmacist under this Act.

17 (e) "Prescription" means and includes any written, oral,
18 facsimile, or electronically transmitted order for drugs or
19 medical devices, issued by a physician licensed to practice
20 medicine in all its branches, dentist, veterinarian, podiatric
21 physician, or optometrist, within the limits of his or her
22 license, by a physician assistant in accordance with
23 subsection (f) of Section 4, or by an advanced practice
24 registered nurse in accordance with subsection (g) of Section
25 4, containing the following: (1) name of the patient; (2) date
26 when prescription was issued; (3) name and strength of drug or

1 description of the medical device prescribed; and (4)
2 quantity; (5) directions for use; (6) prescriber's name,
3 address, and signature; and (7) DEA registration number where
4 required, for controlled substances. The prescription may, but
5 is not required to, list the illness, disease, or condition
6 for which the drug or device is being prescribed. DEA
7 registration numbers shall not be required on inpatient drug
8 orders. A prescription for medication other than controlled
9 substances shall be valid for up to 15 months from the date
10 issued for the purpose of refills, unless the prescription
11 states otherwise.

12 (f) "Person" means and includes a natural person,
13 partnership, association, corporation, government entity, or
14 any other legal entity.

15 (g) "Department" means the Department of Financial and
16 Professional Regulation.

17 (h) "Board of Pharmacy" or "Board" means the State Board
18 of Pharmacy of the Department of Financial and Professional
19 Regulation.

20 (i) "Secretary" means the Secretary of Financial and
21 Professional Regulation.

22 (j) "Drug product selection" means the interchange for a
23 prescribed pharmaceutical product in accordance with Section
24 25 of this Act and Section 3.14 of the Illinois Food, Drug and
25 Cosmetic Act.

26 (k) "Inpatient drug order" means an order issued by an

1 authorized prescriber for a resident or patient of a facility
2 licensed under the Nursing Home Care Act, the ID/DD Community
3 Care Act, the MC/DD Act, the Specialized Mental Health
4 Rehabilitation Act of 2013, the Hospital Licensing Act, or the
5 University of Illinois Hospital Act, or a facility which is
6 operated by the Department of Human Services (as successor to
7 the Department of Mental Health and Developmental
8 Disabilities) or the Department of Corrections.

9 (k-5) "Pharmacist" means an individual health care
10 professional and provider currently licensed by this State to
11 engage in the practice of pharmacy.

12 (l) "Pharmacist in charge" means the licensed pharmacist
13 whose name appears on a pharmacy license and who is
14 responsible for all aspects of the operation related to the
15 practice of pharmacy.

16 (m) "Dispense" or "dispensing" means the interpretation,
17 evaluation, and implementation of a prescription drug order,
18 including the preparation and delivery of a drug or device to a
19 patient or patient's agent in a suitable container
20 appropriately labeled for subsequent administration to or use
21 by a patient in accordance with applicable State and federal
22 laws and regulations. "Dispense" or "dispensing" does not mean
23 the physical delivery to a patient or a patient's
24 representative in a home or institution by a designee of a
25 pharmacist or by common carrier. "Dispense" or "dispensing"
26 also does not mean the physical delivery of a drug or medical

1 device to a patient or patient's representative by a
2 pharmacist's designee within a pharmacy or drugstore while the
3 pharmacist is on duty and the pharmacy is open.

4 (n) "Nonresident pharmacy" means a pharmacy that is
5 located in a state, commonwealth, or territory of the United
6 States, other than Illinois, that delivers, dispenses, or
7 distributes, through the United States Postal Service,
8 commercially acceptable parcel delivery service, or other
9 common carrier, to Illinois residents, any substance which
10 requires a prescription.

11 (o) "Compounding" means the preparation and mixing of
12 components, excluding flavorings, (1) as the result of a
13 prescriber's prescription drug order or initiative based on
14 the prescriber-patient-pharmacist relationship in the course
15 of professional practice or (2) for the purpose of, or
16 incident to, research, teaching, or chemical analysis and not
17 for sale or dispensing. "Compounding" includes the preparation
18 of drugs or devices in anticipation of receiving prescription
19 drug orders based on routine, regularly observed dispensing
20 patterns. Commercially available products may be compounded
21 for dispensing to individual patients only if all of the
22 following conditions are met: (i) the commercial product is
23 not reasonably available from normal distribution channels in
24 a timely manner to meet the patient's needs and (ii) the
25 prescribing practitioner has requested that the drug be
26 compounded.

1 (p) (Blank).

2 (q) (Blank).

3 (r) "Patient counseling" means the communication between a
4 pharmacist or a student pharmacist under the supervision of a
5 pharmacist and a patient or the patient's representative about
6 the patient's medication or device for the purpose of
7 optimizing proper use of prescription medications or devices.
8 "Patient counseling" may include without limitation (1)
9 obtaining a medication history; (2) acquiring a patient's
10 allergies and health conditions; (3) facilitation of the
11 patient's understanding of the intended use of the medication;
12 (4) proper directions for use; (5) significant potential
13 adverse events; (6) potential food-drug interactions; and (7)
14 the need to be compliant with the medication therapy. A
15 pharmacy technician may only participate in the following
16 aspects of patient counseling under the supervision of a
17 pharmacist: (1) obtaining medication history; (2) providing
18 the offer for counseling by a pharmacist or student
19 pharmacist; and (3) acquiring a patient's allergies and health
20 conditions.

21 (s) "Patient profiles" or "patient drug therapy record"
22 means the obtaining, recording, and maintenance of patient
23 prescription information, including prescriptions for
24 controlled substances, and personal information.

25 (t) (Blank).

26 (u) "Medical device" or "device" means an instrument,

1 apparatus, implement, machine, contrivance, implant, in vitro
2 reagent, or other similar or related article, including any
3 component part or accessory, required under federal law to
4 bear the label "Caution: Federal law requires dispensing by or
5 on the order of a physician". A seller of goods and services
6 who, only for the purpose of retail sales, compounds, sells,
7 rents, or leases medical devices shall not, by reasons
8 thereof, be required to be a licensed pharmacy.

9 (v) "Unique identifier" means an electronic signature,
10 handwritten signature or initials, thumb print, or other
11 acceptable biometric or electronic identification process as
12 approved by the Department.

13 (w) "Current usual and customary retail price" means the
14 price that a pharmacy charges to a non-third-party payor.

15 (x) "Automated pharmacy system" means a mechanical system
16 located within the confines of the pharmacy or remote location
17 that performs operations or activities, other than compounding
18 or administration, relative to storage, packaging, dispensing,
19 or distribution of medication, and which collects, controls,
20 and maintains all transaction information.

21 (y) "Drug regimen review" means and includes the
22 evaluation of prescription drug orders and patient records for
23 (1) known allergies; (2) drug or potential therapy
24 contraindications; (3) reasonable dose, duration of use, and
25 route of administration, taking into consideration factors
26 such as age, gender, and contraindications; (4) reasonable

1 directions for use; (5) potential or actual adverse drug
2 reactions; (6) drug-drug interactions; (7) drug-food
3 interactions; (8) drug-disease contraindications; (9)
4 therapeutic duplication; (10) patient laboratory values when
5 authorized and available; (11) proper utilization (including
6 over or under utilization) and optimum therapeutic outcomes;
7 and (12) abuse and misuse.

8 (z) "Electronically transmitted prescription" means a
9 prescription that is created, recorded, or stored by
10 electronic means; issued and validated with an electronic
11 signature; and transmitted by electronic means directly from
12 the prescriber to a pharmacy. An electronic prescription is
13 not an image of a physical prescription that is transferred by
14 electronic means from computer to computer, facsimile to
15 facsimile, or facsimile to computer.

16 (aa) "Medication therapy management services" means a
17 distinct service or group of services offered by licensed
18 pharmacists, physicians licensed to practice medicine in all
19 its branches, advanced practice registered nurses authorized
20 in a written agreement with a physician licensed to practice
21 medicine in all its branches, or physician assistants
22 authorized in guidelines by a supervising physician that
23 optimize therapeutic outcomes for individual patients through
24 improved medication use. In a retail or other non-hospital
25 pharmacy, medication therapy management services shall consist
26 of the evaluation of prescription drug orders and patient

1 medication records to resolve conflicts with the following:

2 (1) known allergies;

3 (2) drug or potential therapy contraindications;

4 (3) reasonable dose, duration of use, and route of
5 administration, taking into consideration factors such as
6 age, gender, and contraindications;

7 (4) reasonable directions for use;

8 (5) potential or actual adverse drug reactions;

9 (6) drug-drug interactions;

10 (7) drug-food interactions;

11 (8) drug-disease contraindications;

12 (9) identification of therapeutic duplication;

13 (10) patient laboratory values when authorized and
14 available;

15 (11) proper utilization (including over or under
16 utilization) and optimum therapeutic outcomes; and

17 (12) drug abuse and misuse.

18 "Medication therapy management services" includes the
19 following:

20 (1) documenting the services delivered and
21 communicating the information provided to patients'
22 prescribers within an appropriate time frame, not to
23 exceed 48 hours;

24 (2) providing patient counseling designed to enhance a
25 patient's understanding and the appropriate use of his or
26 her medications; and

1 (3) providing information, support services, and
2 resources designed to enhance a patient's adherence with
3 his or her prescribed therapeutic regimens.

4 "Medication therapy management services" may also include
5 patient care functions authorized by a physician licensed to
6 practice medicine in all its branches for his or her
7 identified patient or groups of patients under specified
8 conditions or limitations in a standing order from the
9 physician.

10 "Medication therapy management services" in a licensed
11 hospital may also include the following:

12 (1) reviewing assessments of the patient's health
13 status; and

14 (2) following protocols of a hospital pharmacy and
15 therapeutics committee with respect to the fulfillment of
16 medication orders.

17 (bb) "Pharmacist care" means the provision by a pharmacist
18 of medication therapy management services, with or without the
19 dispensing of drugs or devices, intended to achieve outcomes
20 that improve patient health, quality of life, and comfort and
21 enhance patient safety.

22 (cc) "Protected health information" means individually
23 identifiable health information that, except as otherwise
24 provided, is:

25 (1) transmitted by electronic media;

26 (2) maintained in any medium set forth in the

1 definition of "electronic media" in the federal Health
2 Insurance Portability and Accountability Act; or

3 (3) transmitted or maintained in any other form or
4 medium.

5 "Protected health information" does not include
6 individually identifiable health information found in:

7 (1) education records covered by the federal Family
8 Educational Right and Privacy Act; or

9 (2) employment records held by a licensee in its role
10 as an employer.

11 (dd) "Standing order" means a specific order for a patient
12 or group of patients issued by a physician licensed to
13 practice medicine in all its branches in Illinois.

14 (ee) "Address of record" means the designated address
15 recorded by the Department in the applicant's application file
16 or licensee's license file maintained by the Department's
17 licensure maintenance unit.

18 (ff) "Home pharmacy" means the location of a pharmacy's
19 primary operations.

20 (gg) "Email address of record" means the designated email
21 address recorded by the Department in the applicant's
22 application file or the licensee's license file, as maintained
23 by the Department's licensure maintenance unit.

24 (Source: P.A. 102-16, eff. 6-17-21; 102-103, eff. 1-1-22;
25 102-558, eff. 8-20-21; 102-813, eff. 5-13-22; 102-1051, eff.
26 1-1-23; 103-1, eff. 4-27-23.)

1 (225 ILCS 85/9.6)

2 Sec. 9.6. Administration of vaccines and therapeutics by
3 registered pharmacy technicians and student pharmacists.

4 (a) Under the supervision of an appropriately trained
5 pharmacist, a registered pharmacy technician or student
6 pharmacist may administer COVID-19, SARS-CoV-2, respiratory
7 syncytial virus, and influenza vaccines subcutaneously,
8 intramuscularly, or orally as authorized, approved, or
9 licensed by the United States Food and Drug Administration,
10 subject to the following conditions:

11 (1) the vaccination must be ordered by the supervising
12 pharmacist;

13 (2) the supervising pharmacist must be readily and
14 immediately available to the immunizing pharmacy
15 technician or student pharmacist;

16 (3) the pharmacy technician or student pharmacist must
17 complete a practical training program that is approved by
18 the Accreditation Council for Pharmacy Education and that
19 includes hands-on injection technique training and
20 training in the recognition and treatment of emergency
21 reactions to vaccines;

22 (4) the pharmacy technician or student pharmacist must
23 have a current certificate in basic cardiopulmonary
24 resuscitation;

25 (5) the pharmacy technician or student pharmacist must

1 complete, during the relevant licensing period, a minimum
2 of 2 hours of immunization-related continuing pharmacy
3 education that is approved by the Accreditation Council
4 for Pharmacy Education;

5 (6) the supervising pharmacist must comply with all
6 relevant recordkeeping and reporting requirements;

7 (7) the supervising pharmacist must be responsible for
8 complying with requirements related to reporting adverse
9 events;

10 (8) the supervising pharmacist must review the vaccine
11 registry or other vaccination records prior to ordering
12 the vaccination to be administered by the pharmacy
13 technician or student pharmacist;

14 (9) the pharmacy technician or student pharmacist
15 must, if the patient is 18 years of age or younger, inform
16 the patient and the adult caregiver accompanying the
17 patient of the importance of a well-child visit with a
18 pediatrician or other licensed primary-care provider and
19 must refer patients as appropriate;

20 (10) in the case of a COVID-19 vaccine, the
21 vaccination must be ordered and administered according to
22 the Advisory Committee on Immunization Practices' COVID-19
23 vaccine recommendations;

24 (11) in the case of a COVID-19 vaccine, the
25 supervising pharmacist must comply with any applicable
26 requirements or conditions of use as set forth in the

1 Centers for Disease Control and Prevention COVID-19
2 vaccination provider agreement and any other federal
3 requirements that apply to the administration of COVID-19
4 vaccines being administered; and

5 (12) the registered pharmacy technician or student
6 pharmacist and the supervising pharmacist must comply with
7 all other requirements of this Act and the rules adopted
8 thereunder pertaining to the administration of drugs.

9 (b) Under the supervision of an appropriately trained
10 pharmacist, a registered pharmacy technician or student
11 pharmacist may administer COVID-19 therapeutics
12 subcutaneously, intramuscularly, or orally as authorized,
13 approved, or licensed by the United States Food and Drug
14 Administration, subject to the following conditions:

15 (1) the COVID-19 therapeutic must be authorized,
16 approved or licensed by the United States Food and Drug
17 Administration;

18 (2) the COVID-19 therapeutic must be administered
19 subcutaneously, intramuscularly, or orally in accordance
20 with the United States Food and Drug Administration
21 approval, authorization, or licensing;

22 (3) a pharmacy technician or student pharmacist
23 practicing pursuant to this Section must complete a
24 practical training program that is approved by the
25 Accreditation Council for Pharmacy Education and that
26 includes hands-on injection technique training, clinical

1 evaluation of indications and contraindications of
2 COVID-19 therapeutics training, training in the
3 recognition and treatment of emergency reactions to
4 COVID-19 therapeutics, and any additional training
5 required in the United States Food and Drug Administration
6 approval, authorization, or licensing;

7 (4) the pharmacy technician or student pharmacist must
8 have a current certificate in basic cardiopulmonary
9 resuscitation;

10 (5) the pharmacy technician or student pharmacist must
11 comply with any applicable requirements or conditions of
12 use that apply to the administration of COVID-19
13 therapeutics;

14 (6) the supervising pharmacist must comply with all
15 relevant recordkeeping and reporting requirements;

16 (7) the supervising pharmacist must be readily and
17 immediately available to the pharmacy technician or
18 student pharmacist; and

19 (8) the registered pharmacy technician or student
20 pharmacist and the supervising pharmacist must comply with
21 all other requirements of this Act and the rules adopted
22 thereunder pertaining to the administration of drugs.

23 (Source: P.A. 103-1, eff. 4-27-23.)

1 Section 999-99. Effective date. This Act takes effect upon
2 becoming law.".