AN ACT concerning public aid.

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

ARTICLE 5.

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

(305 ILCS 5/5-5)

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

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

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

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

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

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

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

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

Upon receipt of federal approval of an amendment to the

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

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

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

(2) eyeglasses prescribed by a physician skilled in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Department shall not impose a deductible, coinsurance,

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

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

For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Illinois Department, in cooperation with the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

when local government funds finance federal participation for claims payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

organizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 10.

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

(305 ILCS 5/5-5.05h new)

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

ARTICLE 15.

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

(305 ILCS 5/5-5.01a)

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

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

well-being in the most cost-effective manner.

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

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

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

The Medicaid rates for supportive living facilities

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

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

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

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

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

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

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

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

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

including separate entrances;

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

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

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

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

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

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

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

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

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

ARTICLE 20.

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

(210 ILCS 170/40)

Sec. 40. Reimbursement requirements.

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

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

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

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

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

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

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

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

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

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

(305 ILCS 5/5-18.3 new)

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

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

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

laboratory tests, and supplies provided.

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

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

ARTICLE 30.

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

(305 ILCS 5/5H-1)

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

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

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

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

"Fund" means the Healthcare Provider Relief Fund.

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

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

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

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

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

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

(305 ILCS 5/5H-3)

Sec. 5H-3. Managed care assessment.

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

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

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

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

(b) The tiers are established as follows:

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

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

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

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

in order to maximize the revenue generated by the assessment consistent with federal regulations and to meet federal statistical tests necessary for federal financial participation. Any upward adjustment to the Tier 3 rate shall be the minimum necessary to meet federal statistical tests.
(Source: P.A. 101-9, eff. 6-5-19.)

ARTICLE 35.

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

(5 ILCS 100/5-45.55 new)

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

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

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

(305 ILCS 5/14-12.5)

Sec. 14-12.5. Hospital rate updates.

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

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

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

(2) For inpatient psychiatric services:

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

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

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

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

(3) For inpatient rehabilitative services, all

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

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

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

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

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

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

Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 40.

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

(305 ILCS 5/5A-12.7)

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

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

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

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

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

(c) Graduate medical education.

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

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

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

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

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

shall be 22.6%.

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

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

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

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

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

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

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

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

(7) Alzheimer's treatment access payment. Each

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

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

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

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

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

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

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

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

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

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

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

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

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

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

issued.

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

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

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

(C) Long term acute care hospitals.

(D) Freestanding psychiatric hospitals.

(E) Freestanding rehabilitation hospitals.

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

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

(G) High Medicaid hospitals.

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

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

hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Each MCO shall pay each hospital the Monthly

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

(4) Definitions. As used in this subsection:

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

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

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

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

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

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

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

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

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

(A) Hospital inpatient services for critical access hospitals.

(B) Hospital outpatient services for critical access hospitals.

(C) Hospital inpatient services for public hospitals.

(D) Hospital outpatient services for public hospitals.

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

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

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

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

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

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

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

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

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

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

(3) For general acute care hospitals an amount equal

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

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

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

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

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

(8) For high Medicaid hospitals an amount equal to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Definitions. As used in this subsection:

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

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

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

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

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

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

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

rate directed payment class paid during the preceding calendar year.

(j) Pass-through payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 45.

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

(305 ILCS 5/5-5.08a new)

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

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

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

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

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

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

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

ARTICLE 50.

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

(305 ILCS 5/5-5.07)

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

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

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

(305 ILCS 5/14-13)

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

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

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

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

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

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

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

under this subsection shall be reduced by one day.

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

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

ARTICLE 55.

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

(305 ILCS 5/5-55 new)

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

ARTICLE 60.

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

(305 ILCS 5/5-60 new)

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

ARTICLE 65.

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

(305 ILCS 5/5-2.06)

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

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

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

ARTICLE 70.

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

(305 ILCS 5/5-5.24a new)

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

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

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

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

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

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

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

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

ARTICLE 75.

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

(305 ILCS 5/5-2b)

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

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

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

services on December 31, 2023.

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

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

ARTICLE 80.

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

(305 ILCS 5/5-52 new)

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

ARTICLE 85.

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

(305 ILCS 5/5-4.2)

Sec. 5-4.2. Ambulance services payments.

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

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

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

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

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

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

by the Centers for Medicare and Medicaid Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE 90.

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

(305 ILCS 5/5-5)

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

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

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

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

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

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

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

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

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

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

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

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

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

the person may select.

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

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

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

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

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

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

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

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

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

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

(A) A baseline mammogram for individuals 35 to 39

years of age.

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

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

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

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

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

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

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

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

For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

The Department shall establish a methodology to remind

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the conditional enrollment period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notwithstanding any other provision of this Code, within 12 months after June 2, 2022 (the effective date of Public Act 102-1037) and subject to federal approval, acupuncture services performed by an acupuncturist licensed under the

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

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

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

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

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

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

ARTICLE 95.

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

(210 ILCS 49/5-107)

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

their single occupancy rooms. This payment shall be in addition to the rate for recovery and rehabilitation. The additional rate for single room occupancy shall be no less than $10 per day, per single room occupancy. The Department of Healthcare and Family Services shall adjust payment to Medicaid managed care entities to cover these costs. Beginning July 1, 2022, for improving the quality of life and the quality of care, a payment of no less than $5 per day, per single room occupancy shall be added to the existing $10 additional per day, per single room occupancy rate for a total of at least $15 per day, per single room occupancy. For improving the quality of life and the quality of care, on January 1, 2024, a payment of no less than $10.50 per day, per single room occupancy shall be added to the existing $15 additional per day, per single room occupancy rate for a total of at least $25.50 per day, per single room occupancy. <u>For improving the quality of life and the quality of care, beginning on January 1, 2025, a payment of no less than $10 per day, per single room occupancy shall be added to the existing $25.50 additional per day, per single room occupancy rate for a total of at least $35.50 per day, per single room occupancy.</u> Beginning July 1, 2022, for improving the quality of life and the quality of care, an additional payment shall be awarded to a facility for its dual-occupancy rooms. This payment shall be in addition to the rate for recovery and rehabilitation. The additional rate for dual-occupancy rooms shall be no less than $10 per day, per

Medicaid-occupied bed, in each dual-occupancy room. Beginning January 1, 2024, for improving the quality of life and the quality of care, a payment of no less than $4.50 per day, per dual-occupancy room shall be added to the existing $10 additional per day, per dual-occupancy room rate for a total of at least $14.50, per Medicaid-occupied bed, in each dual-occupancy room. Beginning January 1, 2025, for improving the quality of life and the quality of care, a payment of no less than $8.75 per day, per dual-occupancy room shall be added to the existing $14.50 additional per day, per dual-occupancy room rate for a total of at least $23.25, per Medicaid-occupied bed, in each dual-occupancy room. The Department of Healthcare and Family Services shall adjust payment to Medicaid managed care entities to cover these costs. As used in this Section, "dual-occupancy room" means a room that contains 2 resident beds.

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

ARTICLE 100.

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

(305 ILCS 5/5-5.01a)

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

(a) The Department shall establish and provide oversight

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

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

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

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

Medicaid Services.

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

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

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

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

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

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

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

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

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

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

services; and

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

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

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

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

(g) All applications for the expansion of supportive living dementia care settings involving sites not approved by the Department by January 1, 2024 ~~on the effective date of this amendatory Act of the 103rd General Assembly~~ may allow new elderly non-dementia units in addition to new dementia care units. The Department may approve such applications only if the application has: (1) no more than one non-dementia care unit for each dementia care unit and (2) the site is not located within 4 miles of an existing supportive living program site in Cook County (including the City of Chicago), not located within 12 miles of an existing supportive living program site in Alexander, Bond, Boone, Calhoun, Champaign, Clinton, DeKalb, DuPage Fulton, Grundy, Henry, Jackson, Jersey, Johnson, Kane, Kankakee, Kendall, Lake, Macon, Macoupin, Madison, Marshall, McHenry, McLean, Menard, Mercer, Monroe, Peoria, Piatt, Rock Island, Sangamon, Stark, St. Clair, Tazewell, Vermilion, Will, Williamson, Winnebago, or Woodford counties ~~County, Kane County, Lake County, McHenry County, or Will County~~, or not located within 25 miles of an existing supportive living program site in any other county.
(Source: P.A. 102-43, eff. 7-6-21; 102-699, eff. 4-19-22; 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102, Article 100, Section 100-5, eff. 1-1-24; revised 12-15-23.)

ARTICLE 105.

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

(305 ILCS 5/5-36)

Sec. 5-36. Pharmacy benefits.

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

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

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

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

the Department; and

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

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

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

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

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

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

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

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

arrangement;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In this subsection (h-5):

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

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

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

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

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

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

ARTICLE 110.

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

(210 ILCS 49/5-113 new)

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

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

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

ARTICLE 115.

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

(305 ILCS 5/5-53 new)

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

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

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

ARTICLE 120.

(305 ILCS 5/15-6 rep.)

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

Article 125.

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

(30 ILCS 105/5.797)

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

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

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

(305 ILCS 5/12-10.6a)

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

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

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

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

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

Article 130.

(30 ILCS 105/5.836 rep.)

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

(305 ILCS 5/5-31 rep.)

(305 ILCS 5/5-32 rep.)

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

repealing Sections 5-31 and 5-32.

Article 135.

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

(30 ILCS 105/5.481)

Sec. 5.481. The Juvenile Rehabilitation Services Medicaid Matching Fund. This Section is repealed on January 1, 2026.
(Source: P.A. 90-587, eff. 7-1-98.)

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

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

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

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

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

payments to the Department of Human Services for collections made by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) on behalf of the Department of Human Services under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (4) for payment of administrative expenses incurred in performing the activities authorized under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (5) for payment of fees to persons or agencies in the performance of activities pursuant to the collection of monies owed the State that are collected under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (6) for payments of any amounts which are reimbursable to the federal government which are required to be paid by State warrant by either the State or federal government, and (7) for payments to State universities<u>, other State agencies or departments,</u> and local governmental entities of federal funds for services provided to applicants or recipients covered under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act. Disbursements from this Fund for purposes of items (4) and (5) of this paragraph shall be subject to appropriations from the Fund to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid).

The balance in this Fund after payment therefrom of any

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

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

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

(305 ILCS 5/12-10.4)

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

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

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

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

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

Article 140.

(30 ILCS 105/5.856 rep.)

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

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

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

Article 145.

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

(30 ILCS 105/5.409)

Sec. 5.409. The Provider Inquiry Trust Fund. <u>This Section is repealed on January 1, 2025.</u>

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

(30 ILCS 105/6z-40)

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

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

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

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

ARTICLE 150.

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

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

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

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

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

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

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

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

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

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

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

(2) serious impairment to bodily functions;

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

(4) inadequately controlled pain; or

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

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

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

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

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

program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

treatment within 10 days after presentation for emergency services.

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

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

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

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

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

(D) the enrollee is discharged.

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

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

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

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

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

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

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

(f) Network adequacy and transparency.

(1) The Department shall:

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

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

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

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

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

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

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

(g) Timely payment of claims.

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

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

receiving that claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

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

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

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

(g-6) MCO Performance Metrics Report.

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

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

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

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

identified industry.

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

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

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

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

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

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

(A) Premium revenue, with appropriate adjustments.

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

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

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

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

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

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

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

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

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

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

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

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

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

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

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

(g-13) Utilization Review Standardization and Transparency.

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

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

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

(B) procedures that, due to medical complexity,

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

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

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

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

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

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

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

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

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

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

(C) an analysis, for each Medicaid MCO, of the number of service authorization requests, including requests for concurrent review and certification of admissions, received, initially denied, overturned through any post-denial process including, but not limited to, enrollee or provider appeal, peer-to-peer review, or the provider dispute resolution process, denied but approved for a lower or different level of care, and the number denied on final determination; and

(D) provide a written report to the General Assembly, detailing the items listed in this subsection and any other metrics deemed necessary by the Department, by the second April, following the effective date of this amendatory Act of the 103rd General Assembly, and each April thereafter. The Department shall make this report available within 30 days of delivery to the General Assembly, on its public facing website.

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already

designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(h-5) Leading indicator data sharing. By January 1, 2024, the Department shall obtain input from the Department of Human Services, the Department of Juvenile Justice, the Department of Children and Family Services, the State Board of Education, managed care organizations, providers, and clinical experts to identify and analyze key indicators from assessments and data sets available to the Department that can be shared with managed care organizations and similar care coordination entities contracted with the Department as leading indicators for elevated behavioral health crisis risk for children. To the extent permitted by State and federal law, the identified leading indicators shall be shared with managed care organizations and similar care coordination entities contracted with the Department within 6 months of identification for the purpose of improving care coordination with the early detection of elevated risk. Leading indicators shall be reassessed annually with stakeholder input.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public

Act 98-651).

(j) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form that grants to the health care provider permission to release the recipient's health care information to the recipient's insurance carrier.

(k) The Department of Healthcare and Family Services, managed care organizations, a statewide organization representing hospitals, and a statewide organization representing safety-net hospitals shall explore ways to support billing departments in safety-net hospitals.

(l) The requirements of this Section added by Public Act 102-4 shall apply to services provided on or after the first day of the month that begins 60 days after April 27, 2021 (the effective date of Public Act 102-4).

(m) Except where otherwise expressly specified, the requirements of this Section added by this amendatory Act of the 103rd General Assembly shall apply to services provided on or after July 1, 2025.

(Source: P.A. 102-4, eff. 4-27-21; 102-43, eff. 7-6-21; 102-144, eff. 1-1-22; 102-454, eff. 8-20-21; 102-813, eff.

5-13-22; 103-546, eff. 8-11-23.)

(305 ILCS 5/5-30.18 new)

Sec. 5-30.18. Service authorization program performance.

(a) Definitions. As used in this Section:

"Gold Card provider" means a provider identified by each Medicaid Managed Care Organization (MCO) as qualified under the guidelines outlined by the Department in accordance with subsection (c) and thereby granted a service authorization exemption when ordering a health care service.

"Health care service" means any medical or behavioral health service covered under the medical assistance program that is rendered in the inpatient or outpatient hospital setting, including hospital-based clinics, and subject to review under a service authorization program.

"Provider" means an individual actively enrolled in the medical assistance program and licensed or otherwise authorized to order, prescribe, refer, or render health care services in this State, and, as determined by the Department, may also include hospitals that submit service authorization requests.

"Service authorization exemption" means an exception granted by a Medicaid MCO to a provider under which all service authorization requests for covered health care services, excluding pharmacy services and durable medical equipment, are automatically deemed to be medically necessary, clinically

appropriate, and approved for reimbursement as ordered.

"Service authorization program" means any utilization review, utilization management, peer review, quality review, or other medical management activity conducted in advance of, concurrent to, or after the provision of a health care service by a Medicaid MCO, either directly or through a contracted utilization review organization (URO), including, but not limited to, prior authorization, pre-certification, certification of admission, concurrent review, and retrospective review of health care services.

"Service authorization request" means a request by a provider to a service authorization program to determine whether a health care service that is otherwise covered under the medical assistance program meets the reimbursement requirements established by the Medicaid MCO, or its contracted URO, for medically necessary, clinically appropriate care and to issue a service authorization determination.

"Utilization review organization" or "URO" means a managed care organization or other entity that has established or administers one or more service authorization programs.

(b) In consultation with the Medicaid MCOs, a statewide association representing managed care organizations, a statewide association representing the majority of Illinois hospitals, and a statewide association representing physicians, the Department shall in accordance with the

Illinois Administrative Procedure Act, adopt administrative rules, consistent with this Section, to require each Medicaid MCO to identify Gold Card providers with such identification initially being effective for health care services provided on and after July 1, 2025.

(c) The Department shall adopt rules, in accordance with the Illinois Administrative Procedure Act, to implement this Section that include, but are not limited to, the following provisions:

(1) Require each Medicaid MCO to provide a service authorization exemption to a provider if the provider has submitted at least 50 service authorization requests to its service authorization program in the preceding calendar year and the service authorization program approved at least 90% of all service authorization requests, regardless of the type of health care services requested.

(2) Require that service authorization exemptions be limited to services provided in an inpatient or outpatient hospital setting inclusive of hospital-based clinics. Service authorization exemptions under this Section shall not pertain to pharmacy services and durable medical equipment and supplies.

(3) The service authorization exemption shall be valid for at least one year, shall be made by each Medicaid MCO or its URO, and shall be binding on the Medicaid MCO and

its URO.

(4) The provider shall be required to continue to document medically necessary, clinically appropriate care and submit such documentation to the Medicaid MCO for the purpose of continuous performance monitoring. If a provider fails to maintain the 90% service authorization standard, as determined on no more frequent a basis than bi-annually, the provider's service authorization exemption is subject to temporary or permanent suspension.

(5) Require that each Medicaid MCO publish on its provider portal a list of all providers that have qualified for a service authorization exemption or indicate that a provider has qualified for a service authorization exemption on its provider-facing provider roster.

(6) Require that no later than December 1 of each calendar year, each Medicaid MCO shall provide written notification to all providers who qualify for a service authorization exemption, for the subsequent calendar year.

(7) Require that each Medicaid MCO or its URO use the policies and guidelines published by the Department to evaluate whether a provider meets the criteria to qualify for a service authorization exemption and the conditions under which a service authorization exemption may be rescinded, including review of the provider's service authorization determinations during the preceding calendar

year.

(8) Require each Medicaid MCO to provide the Department a list of all providers who were denied a service authorization exemption or had a previously granted service authorization exemption suspended, with such denials being subject to an annual audit conducted by an independent third-party URO to ensure their appropriateness.

(A) The independent third-party URO shall issue a written report consistent with this paragraph.

(B) The independent third-party URO shall not be owned by, affiliated with, or employed by any Medicaid MCO or its contracted URO, nor shall it have any financial interest in the Medicaid MCO's service authorization exemption program.

(d) Each Medicaid MCO must have a standard method to accept and process professional claims and facility claims, as billed by the provider, for a health care service that is rendered, prescribed, or ordered by a provider granted a service authorization exemption, except in cases of fraud.

(e) A service authorization program shall not deny, partially deny, reduce the level of care, or otherwise limit reimbursement to the rendering or supervising provider, including the rendering facility, for health care services ordered by a provider who qualifies for a service authorization exemption, except in cases of fraud.

(f) This Section is repealed on December 31, 2030.

ARTICLE 155.

Section 155-5. The Community-Integrated Living Arrangements Licensure and Certification Act is amended by adding Section 13.3 as follows:

(210 ILCS 135/13.3 new)

Sec. 13.3. Community-integrated living arrangement per diem reimbursement. As used in this Section, "medical absence" means a situation in which a resident is temporarily absent from a community-integrated living arrangement to receive medical treatment or for other reasons that have been recommended by third-party medical personnel, including, but not limited to, hospitalizations, placements in short-term stabilization homes or State-operated facilities, stays in nursing facilities, rehabilitation in long-term care facilities, or other absences for legitimate medical reasons.

Beginning January 1, 2025, the Department's Division of Developmental Disabilities shall provide 100% of the per diem reimbursement to a 24-hour community-integrated living arrangement provider for up to 20 days for any resident requiring a medical absence. During the medical absence, the provider shall hold the bed for the resident. After the medical absence, the resident shall return to the

community-integrated living arrangement when the resident is medically able to return in order for the provider to receive the full per diem reimbursement for the absent days. The per diem reimbursement shall be in addition to the existing occupancy factor policy set by the Division of Developmental Disabilities.

ARTICLE 160.

Section 160-5. The Illinois Public Aid Code is amended by adding Section 5-5.12f as follows:

(305 ILCS 5/5-5.12f new)

Sec. 5-5.12f. Prescription drugs for mental illness; no utilization or prior approval mandates.

(a) Notwithstanding any other provision of this Code to the contrary, except as otherwise provided in subsection (b), for the purpose of removing barriers to the timely treatment of serious mental illnesses, prior authorization mandates and utilization management controls shall not be imposed under the fee-for-service and managed care medical assistance programs on any FDA-approved prescription drug that is recognized by a generally accepted standard medical reference as effective in the treatment of conditions specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association if a

preferred or non-preferred drug is prescribed to an adult patient to treat serious mental illness and one of the following applies:

(1) the patient has changed providers, including, but not limited to, a change from an inpatient to an outpatient provider, and is stable on the drug that has been previously prescribed, and received prior authorization, if required;

(2) the patient has changed insurance coverage and is stable on the drug that has been previously prescribed and received prior authorization under the previous source of coverage; or

(3) subject to federal law on maximum dosage limits and safety edits adopted by the Department's Drug and Therapeutics Board, including those safety edits and limits needed to comply with federal requirements contained in 42 CFR 456.703, the patient has previously been prescribed and obtained prior authorization for the drug and the prescription modifies the dosage, dosage frequency, or both, of the drug as part of the same treatment for which the drug was previously prescribed.

(b) The following safety edits shall be permitted for prescription drugs covered under this Section:

(1) clinically appropriate drug utilization review (DUR) edits, including, but not limited to, drug-to-drug, drug-age, and drug-dose;

(2) generic drug substitution if a generic drug is available for the prescribed medication in the same dosage and formulation; and

(3) any utilization management control that is necessary for the Department to comply with any current consent decrees or federal waivers.

(c) As used in this Section, "serious mental illness" means any one or more of the following diagnoses and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes listed by the Department of Human Services' Division of Mental Health, as amended, on its official website:

(1) Delusional Disorder (F22)

(2) Brief Psychotic Disorder (F23)

(3) Schizophreniform Disorder (F20.81)

(4) Schizophrenia (F20.9)

(5) Schizoaffective Disorder (F25.x)

(6) Catatonia Associated with Another Mental Disorder (Catatonia Specifier) (F06.1)

(7) Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (F28)

(8) Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (F29)

(9) Bipolar I Disorder (F31.xx)

(10) Bipolar II Disorder (F31.81)

(11) Cyclothymic Disorder (F34.0)

(12) Unspecified Bipolar and Related Disorder (F31.9)

(13) Disruptive Mood Dysregulation Disorder (F34.8)

(14) Major Depressive Disorder Single episode (F32.xx)

(15) Major Depressive Disorder, Recurrent episode (F33.xx)

(16) Obsessive-Compulsive Disorder (F42)

(17) Posttraumatic Stress Disorder (F43.10)

(18) Anorexia Nervosa (F50.0x)

(19) Bulimia Nervosa (F50.2)

(20) Postpartum Depression (F53.0)

(21) Puerperal Psychosis (F53.1)

(22) Factitious Disorder Imposed on Another (F68.A)

(d) Notwithstanding any other provision of law, nothing in this Section shall not be construed to conflict with Section 1927(a)(1) and (b)(1)(A) of the federal Social Security Act and any implementing regulations and agreements.

ARTICLE 165.

Section 165-5. The Illinois Public Aid Code is amended by changing Section 5-5.01a as follows:

(305 ILCS 5/5-5.01a)

Sec. 5-5.01a. Supportive living facilities program.

(a) The Department shall establish and provide oversight for a program of supportive living facilities that seek to

promote resident independence, dignity, respect, and well-being in the most cost-effective manner.

A supportive living facility is (i) a free-standing facility or (ii) a distinct physical and operational entity within a mixed-use building that meets the criteria established in subsection (d). A supportive living facility integrates housing with health, personal care, and supportive services and is a designated setting that offers residents their own separate, private, and distinct living units.

Sites for the operation of the program shall be selected by the Department based upon criteria that may include the need for services in a geographic area, the availability of funding, and the site's ability to meet the standards.

(b) Beginning July 1, 2014, subject to federal approval, the Medicaid rates for supportive living facilities shall be equal to the supportive living facility Medicaid rate effective on June 30, 2014 increased by 8.85%. Once the assessment imposed at Article V-G of this Code is determined to be a permissible tax under Title XIX of the Social Security Act, the Department shall increase the Medicaid rates for supportive living facilities effective on July 1, 2014 by 9.09%. The Department shall apply this increase retroactively to coincide with the imposition of the assessment in Article V-G of this Code in accordance with the approval for federal financial participation by the Centers for Medicare and Medicaid Services.

The Medicaid rates for supportive living facilities effective on July 1, 2017 must be equal to the rates in effect for supportive living facilities on June 30, 2017 increased by 2.8%.

The Medicaid rates for supportive living facilities effective on July 1, 2018 must be equal to the rates in effect for supportive living facilities on June 30, 2018.

Subject to federal approval, the Medicaid rates for supportive living services on and after July 1, 2019 must be at least 54.3% of the average total nursing facility services per diem for the geographic areas defined by the Department while maintaining the rate differential for dementia care and must be updated whenever the total nursing facility service per diems are updated. Beginning July 1, 2022, upon the implementation of the Patient Driven Payment Model, Medicaid rates for supportive living services must be at least 54.3% of the average total nursing services per diem rate for the geographic areas. For purposes of this provision, the average total nursing services per diem rate shall include all add-ons for nursing facilities for the geographic area provided for in Section 5-5.2. The rate differential for dementia care must be maintained in these rates and the rates shall be updated whenever nursing facility per diem rates are updated.

Subject to federal approval, beginning January 1, 2024, the dementia care rate for supportive living services must be no less than the non-dementia care supportive living services

rate multiplied by 1.5.

(c) The Department may adopt rules to implement this Section. Rules that establish or modify the services, standards, and conditions for participation in the program shall be adopted by the Department in consultation with the Department on Aging, the Department of Rehabilitation Services, and the Department of Mental Health and Developmental Disabilities (or their successor agencies).

(d) Subject to federal approval by the Centers for Medicare and Medicaid Services, the Department shall accept for consideration of certification under the program any application for a site or building where distinct parts of the site or building are designated for purposes other than the provision of supportive living services, but only if:

(1) those distinct parts of the site or building are not designated for the purpose of providing assisted living services as required under the Assisted Living and Shared Housing Act;

(2) those distinct parts of the site or building are completely separate from the part of the building used for the provision of supportive living program services, including separate entrances;

(3) those distinct parts of the site or building do not share any common spaces with the part of the building used for the provision of supportive living program services; and

(4) those distinct parts of the site or building do not share staffing with the part of the building used for the provision of supportive living program services.

(e) Facilities or distinct parts of facilities which are selected as supportive living facilities and are in good standing with the Department's rules are exempt from the provisions of the Nursing Home Care Act and the Illinois Health Facilities Planning Act.

(f) Section 9817 of the American Rescue Plan Act of 2021 (Public Law 117-2) authorizes a 10% enhanced federal medical assistance percentage for supportive living services for a 12-month period from April 1, 2021 through March 31, 2022. Subject to federal approval, including the approval of any necessary waiver amendments or other federally required documents or assurances, for a 12-month period the Department must pay a supplemental $26 per diem rate to all supportive living facilities with the additional federal financial participation funds that result from the enhanced federal medical assistance percentage from April 1, 2021 through March 31, 2022. The Department may issue parameters around how the supplemental payment should be spent, including quality improvement activities. The Department may alter the form, methods, or timeframes concerning the supplemental per diem rate to comply with any subsequent changes to federal law, changes made by guidance issued by the federal Centers for Medicare and Medicaid Services, or other changes necessary to

receive the enhanced federal medical assistance percentage.

(g) All applications for the expansion of supportive living dementia care settings involving sites not approved by the Department on January 1, 2024 (the effective date of Public Act 103-102) ~~this amendatory Act of the 103rd General Assembly~~ may allow new elderly non-dementia units in addition to new dementia care units. The Department may approve such applications only if the application has: (1) no more than one non-dementia care unit for each dementia care unit and (2) the site is not located within 4 miles of an existing supportive living program site in Cook County (including the City of Chicago), not located within 12 miles of an existing supportive living program site in DuPage County, Kane County, Lake County, McHenry County, or Will County, or not located within 25 miles of an existing supportive living program site in any other county.

(h) As stated in the supportive living program home and community-based service waiver approved by the federal Centers for Medicare and Medicaid Services, and beginning July 1, 2025, the Department must maintain the rate add-on implemented on January 1, 2023 for the provision of 2 meals per day at no less than $6.15 per day.

(Source: P.A. 102-43, eff. 7-6-21; 102-699, eff. 4-19-22; 103-102, Article 20, Section 20-5, eff. 1-1-24; 103-102, Article 100, Section 100-5, eff. 1-1-24; revised 12-15-23.)

ARTICLE 170.

Section 170-5. The Illinois Public Aid Code is amended by adding Section 5-2.06a as follows:

(305 ILCS 5/5-2.06a new)

Sec. 5-2.06a. Medically fragile children; reimbursement for legally responsible family caregivers. By January 1, 2025, the Department of Healthcare and Family Services shall apply for a Home and Community-Based Services State Plan amendment and any federal waiver necessary to reimburse legally responsible family caregivers as providers of personal care or home health aide services under the Illinois Title XIX State Plan Home and Community-Based Services benefit and the home and community-based services waiver program authorized under Section 1915(c) of the Social Security Act for persons who are medically fragile and technology dependent. To be eligible for reimbursement under this Section, a legally responsible family caregiver must be a certified nursing assistant or certified nurse aide and must provide services to a medically fragile relative who is receiving in-home shift nursing services coordinated by the University of Illinois at Chicago, Division of Specialized Care for Children. Upon federal approval of the State Plan amendment and waiver, the Department shall promulgate rules that define who qualifies for reimbursement as a legally responsible family caregiver, specify which

personal care and home health aide services are eligible for reimbursement if the provider is a legally responsible family caregiver, establish oversight policies to ensure legally responsible family caregivers meet and comply with licensing and program requirements, and adopt any other policies or procedures necessary to implement this Section.

ARTICLE 175.

Section 175-5. The Illinois Public Aid Code is amended by changing Section 5-5.5 as follows:

(305 ILCS 5/5-5.5) (from Ch. 23, par. 5-5.5)

Sec. 5-5.5. Elements of Payment Rate.

(a) The Department of Healthcare and Family Services shall develop a prospective method for determining payment rates for nursing facility and ICF/DD services in nursing facilities composed of the following cost elements:

(1) Standard Services, with the cost of this component being determined by taking into account the actual costs to the facilities of these services subject to cost ceilings to be defined in the Department's rules.

(2) Resident Services, with the cost of this component being determined by taking into account the actual costs, needs and utilization of these services, as derived from an assessment of the resident needs in the nursing

facilities.

(3) Ancillary Services, with the payment rate being developed for each individual type of service. Payment shall be made only when authorized under procedures developed by the Department of Healthcare and Family Services.

(4) Nurse's Aide Training, with the cost of this component being determined by taking into account the actual cost to the facilities of such training.

(5) Real Estate Taxes, with the cost of this component being determined by taking into account the figures contained in the most currently available cost reports (with no imposition of maximums) updated to the midpoint of the current rate year for long term care services rendered between July 1, 1984 and June 30, 1985, and with the cost of this component being determined by taking into account the actual 1983 taxes for which the nursing homes were assessed (with no imposition of maximums) updated to the midpoint of the current rate year for long term care services rendered between July 1, 1985 and June 30, 1986.

(b) In developing a prospective method for determining payment rates for nursing facility and ICF/DD services in nursing facilities and ICF/DDs, the Department of Healthcare and Family Services shall consider the following cost elements:

(1) Reasonable capital cost determined by utilizing

incurred interest rate and the current value of the investment, including land, utilizing composite rates, or by utilizing such other reasonable cost related methods determined by the Department. However, beginning with the rate reimbursement period effective July 1, 1987, the Department shall be prohibited from establishing, including, and implementing any depreciation factor in calculating the capital cost element.

(2) Profit, with the actual amount being produced and accruing to the providers in the form of a return on their total investment, on the basis of their ability to economically and efficiently deliver a type of service. The method of payment may assure the opportunity for a profit, but shall not guarantee or establish a specific amount as a cost.

(c) The Illinois Department may implement the amendatory changes to this Section made by this amendatory Act of 1991 through the use of emergency rules in accordance with the provisions of Section 5.02 of the Illinois Administrative Procedure Act. For purposes of the Illinois Administrative Procedure Act, the adoption of rules to implement the amendatory changes to this Section made by this amendatory Act of 1991 shall be deemed an emergency and necessary for the public interest, safety and welfare.

(d) No later than January 1, 2001, the Department of Public Aid shall file with the Joint Committee on

Administrative Rules, pursuant to the Illinois Administrative Procedure Act, a proposed rule, or a proposed amendment to an existing rule, regarding payment for appropriate services, including assessment, care planning, discharge planning, and treatment provided by nursing facilities to residents who have a serious mental illness.

(e) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(f) Beginning January 1, 2025, the real estate tax component of the payment rate shall be updated using the most recent property tax bill on file with the Department for facilities licensed under the Nursing Home Care Act and facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013. The per diem rate shall be computed by dividing the real estate tax costs reported in the cost report inflated to the midpoint of the rate year by the total number of patient days reported in the same cost report. Computation of the real estate tax component shall be based on capital days.

(Source: P.A. 96-1123, eff. 1-1-11; 96-1530, eff. 2-16-11; 97-689, eff. 6-14-12.)

ARTICLE 180.

Section 180-5. The Illinois Public Aid Code is amended by changing Section 5-5.2 as follows:

(305 ILCS 5/5-5.2)

Sec. 5-5.2. Payment.

(a) All nursing facilities that are grouped pursuant to Section 5-5.1 of this Act shall receive the same rate of payment for similar services.

(b) It shall be a matter of State policy that the Illinois Department shall utilize a uniform billing cycle throughout the State for the long-term care providers.

(c) (Blank).

(c-1) Notwithstanding any other provisions of this Code, the methodologies for reimbursement of nursing services as provided under this Article shall no longer be applicable for bills payable for nursing services rendered on or after a new reimbursement system based on the Patient Driven Payment Model (PDPM) has been fully operationalized, which shall take effect for services provided on or after the implementation of the PDPM reimbursement system begins. For the purposes of Public Act 102-1035 ~~this amendatory Act of the 102nd General Assembly~~, the implementation date of the PDPM reimbursement system and all related provisions shall be July 1, 2022 if the following conditions are met: (i) the Centers for Medicare and Medicaid Services has approved corresponding changes in the

reimbursement system and bed assessment; and (ii) the Department has filed rules to implement these changes no later than June 1, 2022. Failure of the Department to file rules to implement the changes provided in Public Act 102-1035 ~~this amendatory Act of the 102nd General Assembly~~ no later than June 1, 2022 shall result in the implementation date being delayed to October 1, 2022.

(d) The new nursing services reimbursement methodology utilizing the Patient Driven Payment Model, which shall be referred to as the PDPM reimbursement system, taking effect July 1, 2022, upon federal approval by the Centers for Medicare and Medicaid Services, shall be based on the following:

(1) The methodology shall be resident-centered, facility-specific, cost-based, and based on guidance from the Centers for Medicare and Medicaid Services.

(2) Costs shall be annually rebased and case mix index quarterly updated. The nursing services methodology will be assigned to the Medicaid enrolled residents on record as of 30 days prior to the beginning of the rate period in the Department's Medicaid Management Information System (MMIS) as present on the last day of the second quarter preceding the rate period based upon the Assessment Reference Date of the Minimum Data Set (MDS).

(3) Regional wage adjustors based on the Health Service Areas (HSA) groupings and adjusters in effect on

April 30, 2012 shall be included, except no adjuster shall be lower than 1.06.

(4) PDPM nursing case mix indices in effect on March 1, 2022 shall be assigned to each resident class at no less than 0.7858 of the Centers for Medicare and Medicaid Services PDPM unadjusted case mix values, in effect on March 1, 2022.

(5) The pool of funds available for distribution by case mix and the base facility rate shall be determined using the formula contained in subsection (d-1).

(6) The Department shall establish a variable per diem staffing add-on in accordance with the most recent available federal staffing report, currently the Payroll Based Journal, for the same period of time, and if applicable adjusted for acuity using the same quarter's MDS. The Department shall rely on Payroll Based Journals provided to the Department of Public Health to make a determination of non-submission. If the Department is notified by a facility of missing or inaccurate Payroll Based Journal data or an incorrect calculation of staffing, the Department must make a correction as soon as the error is verified for the applicable quarter.

Beginning October 1, 2024, the staffing percentage used in the calculation of the per diem staffing add-on shall be its PDPM STRIVE Staffing Ratio which equals: its Reported Total Nurse Staffing Hours Per Resident Per Day

as published in the most recent federal staffing report (the Provider Information File), divided by the facility's PDPM STRIVE Staffing Target. Each facility's PDPM STRIVE Staffing Target is equal to .82 times the facility's Illinois Adjusted Facility Case-Mix Hours Per Resident Per Day. A facility's Illinois Adjusted Facility Case Mix Hours Per Resident Per Day is equal to its Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the most recent federal staffing report) times 3.662 (which reflects the national resident days-weighted mean Reported Total Nurse Staffing Hours Per Resident Per Day as calculated using the January 2024 federal Provider Information Files), divided by the national resident days-weighted mean Reported Total Nurse Staffing Hours Per Resident Per Day calculated using the most recent federal Provider Information File.

(6.5) Beginning July 1, 2024, the paid per diem staffing add-on shall be the paid per diem staffing add-on in effect April 1, 2024. For dates beginning October 1, 2024 and through September 30, 2025, the denominator for the staffing percentage shall be the lesser of the facility's PDPM STRIVE Staffing Target and:

(A) For the quarter beginning October 1, 2024, the sum of 20% of the facility's PDPM STRIVE Staffing Target and 80% of the facility's Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in

the January 2024 federal staffing report).

(B) For the quarter beginning January 1, 2025, the sum of 40% of the facility's PDPM STRIVE Staffing Target and 60% of the facility's Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the January 2024 federal staffing report).

(C) For the quarter beginning March 1, 2025, the sum of 60% of the facility's PDPM STRIVE Staffing Target and 40% of the facility's Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the January 2024 federal staffing report).

(D) For the quarter beginning July 1, 2025, the sum of 80% of the facility's PDPM STRIVE Staffing Target and 20% of the facility's Case-Mix Total Nurse Staffing Hours Per Resident Per Day (as published in the January 2024 federal staffing report).

Facilities with at least 70% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $9, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem of $16.52 ~~$14.88~~. Facilities with at least 80% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $16.52 ~~$14.88~~, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $25.77 ~~$23.80~~. Facilities with at least 92% of the staffing indicated by the STRIVE study

shall be paid a per diem add-on of $25.77 ~~$23.80~~, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $30.98 ~~$29.75~~. Facilities with at least 100% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $30.98 ~~$29.75~~, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $36.44 ~~$35.70~~. Facilities with at least 110% of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $36.44 ~~$35.70~~, increasing by equivalent steps for each whole percentage point until the facilities reach a per diem add-on of $38.68. Facilities with at least 125% or higher of the staffing indicated by the STRIVE study shall be paid a per diem add-on of $38.68. No ~~Beginning April 1, 2023, no~~ nursing facility's variable staffing per diem add-on shall be reduced by more than 5% in 2 consecutive quarters. For the quarters beginning July 1, 2022 and October 1, 2022, no facility's variable per diem staffing add-on shall be calculated at a rate lower than 85% of the staffing indicated by the STRIVE study. No facility below 70% of the staffing indicated by the STRIVE study shall receive a variable per diem staffing add-on after December 31, 2022.

(7) For dates of services beginning July 1, 2022, the PDPM nursing component per diem for each nursing facility shall be the product of the facility's (i) statewide PDPM

nursing base per diem rate, $92.25, adjusted for the facility average PDPM case mix index calculated quarterly and (ii) the regional wage adjuster, and then add the Medicaid access adjustment as defined in (e-3) of this Section. Transition rates for services provided between July 1, 2022 and October 1, 2023 shall be the greater of the PDPM nursing component per diem or:

(A) for the quarter beginning July 1, 2022, the RUG-IV nursing component per diem;

(B) for the quarter beginning October 1, 2022, the sum of the RUG-IV nursing component per diem multiplied by 0.80 and the PDPM nursing component per diem multiplied by 0.20;

(C) for the quarter beginning January 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.60 and the PDPM nursing component per diem multiplied by 0.40;

(D) for the quarter beginning April 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.40 and the PDPM nursing component per diem multiplied by 0.60;

(E) for the quarter beginning July 1, 2023, the sum of the RUG-IV nursing component per diem multiplied by 0.20 and the PDPM nursing component per diem multiplied by 0.80; or

(F) for the quarter beginning October 1, 2023 and

each subsequent quarter, the transition rate shall end and a nursing facility shall be paid 100% of the PDPM nursing component per diem.

(d-1) Calculation of base year Statewide RUG-IV nursing base per diem rate.

(1) Base rate spending pool shall be:

(A) The base year resident days which are calculated by multiplying the number of Medicaid residents in each nursing home as indicated in the MDS data defined in paragraph (4) by 365.

(B) Each facility's nursing component per diem in effect on July 1, 2012 shall be multiplied by subsection (A).

(C) Thirteen million is added to the product of subparagraph (A) and subparagraph (B) to adjust for the exclusion of nursing homes defined in paragraph (5).

(2) For each nursing home with Medicaid residents as indicated by the MDS data defined in paragraph (4), weighted days adjusted for case mix and regional wage adjustment shall be calculated. For each home this calculation is the product of:

(A) Base year resident days as calculated in subparagraph (A) of paragraph (1).

(B) The nursing home's regional wage adjustor based on the Health Service Areas (HSA) groupings and

adjustors in effect on April 30, 2012.

(C) Facility weighted case mix which is the number of Medicaid residents as indicated by the MDS data defined in paragraph (4) multiplied by the associated case weight for the RUG-IV 48 grouper model using standard RUG-IV procedures for index maximization.

(D) The sum of the products calculated for each nursing home in subparagraphs (A) through (C) above shall be the base year case mix, rate adjusted weighted days.

(3) The Statewide RUG-IV nursing base per diem rate:

(A) on January 1, 2014 shall be the quotient of the paragraph (1) divided by the sum calculated under subparagraph (D) of paragraph (2);

(B) on and after July 1, 2014 and until July 1, 2022, shall be the amount calculated under subparagraph (A) of this paragraph (3) plus $1.76; and

(C) beginning July 1, 2022 and thereafter, $7 shall be added to the amount calculated under subparagraph (B) of this paragraph (3) of this Section.

(4) Minimum Data Set (MDS) comprehensive assessments for Medicaid residents on the last day of the quarter used to establish the base rate.

(5) Nursing facilities designated as of July 1, 2012 by the Department as "Institutions for Mental Disease"

shall be excluded from all calculations under this subsection. The data from these facilities shall not be used in the computations described in paragraphs (1) through (4) above to establish the base rate.

(e) Beginning July 1, 2014, the Department shall allocate funding in the amount up to $10,000,000 for per diem add-ons to the RUGS methodology for dates of service on and after July 1, 2014:

(1) $0.63 for each resident who scores in I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

(2) $2.67 for each resident who scores either a "1" or "2" in any items S1200A through S1200I and also scores in RUG groups PA1, PA2, BA1, or BA2.

(e-1) (Blank).

(e-2) For dates of services beginning January 1, 2014 and ending September 30, 2023, the RUG-IV nursing component per diem for a nursing home shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index, and the regional wage adjustor. For dates of service beginning July 1, 2022 and ending September 30, 2023, the Medicaid access adjustment described in subsection (e-3) shall be added to the product.

(e-3) A Medicaid Access Adjustment of $4 adjusted for the facility average PDPM case mix index calculated quarterly shall be added to the statewide PDPM nursing per diem for all facilities with annual Medicaid bed days of at least 70% of all

occupied bed days adjusted quarterly. For each new calendar year and for the 6-month period beginning July 1, 2022, the percentage of a facility's occupied bed days comprised of Medicaid bed days shall be determined by the Department quarterly. For dates of service beginning January 1, 2023, the Medicaid Access Adjustment shall be increased to $4.75. This subsection shall be inoperative on and after January 1, 2028.

(e-4) Subject to federal approval, on and after January 1, 2024, the Department shall increase the rate add-on at paragraph (7) subsection (a) under 89 Ill. Adm. Code 147.335 for ventilator services from $208 per day to $481 per day. Payment is subject to the criteria and requirements under 89 Ill. Adm. Code 147.335.

(f) (Blank).

(g) Notwithstanding any other provision of this Code, on and after July 1, 2012, for facilities not designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease", rates effective May 1, 2011 shall be adjusted as follows:

(1) (Blank);

(2) (Blank);

(3) Facility rates for the capital and support components shall be reduced by 1.7%.

(h) Notwithstanding any other provision of this Code, on and after July 1, 2012, nursing facilities designated by the Department of Healthcare and Family Services as "Institutions

for Mental Disease" and "Institutions for Mental Disease" that are facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall have the nursing, socio-developmental, capital, and support components of their reimbursement rate effective May 1, 2011 reduced in total by 2.7%.

(i) On and after July 1, 2014, the reimbursement rates for the support component of the nursing facility rate for facilities licensed under the Nursing Home Care Act as skilled or intermediate care facilities shall be the rate in effect on June 30, 2014 increased by 8.17%.

(i-1) Subject to federal approval, on and after January 1, 2024, the reimbursement rates for the support component of the nursing facility rate for facilities licensed under the Nursing Home Care Act as skilled or intermediate care facilities shall be the rate in effect on June 30, 2023 increased by 12%.

(j) Notwithstanding any other provision of law, subject to federal approval, effective July 1, 2019, sufficient funds shall be allocated for changes to rates for facilities licensed under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities for dates of services on and after July 1, 2019: (i) to establish, through June 30, 2022 a per diem add-on to the direct care per diem rate not to exceed $70,000,000 annually in the aggregate taking into account federal matching funds for the purpose of

addressing the facility's unique staffing needs, adjusted quarterly and distributed by a weighted formula based on Medicaid bed days on the last day of the second quarter preceding the quarter for which the rate is being adjusted. Beginning July 1, 2022, the annual $70,000,000 described in the preceding sentence shall be dedicated to the variable per diem add-on for staffing under paragraph (6) of subsection (d); and (ii) in an amount not to exceed $170,000,000 annually in the aggregate taking into account federal matching funds to permit the support component of the nursing facility rate to be updated as follows:

(1) 80%, or $136,000,000, of the funds shall be used to update each facility's rate in effect on June 30, 2019 using the most recent cost reports on file, which have had a limited review conducted by the Department of Healthcare and Family Services and will not hold up enacting the rate increase, with the Department of Healthcare and Family Services.

(2) After completing the calculation in paragraph (1), any facility whose rate is less than the rate in effect on June 30, 2019 shall have its rate restored to the rate in effect on June 30, 2019 from the 20% of the funds set aside.

(3) The remainder of the 20%, or $34,000,000, shall be used to increase each facility's rate by an equal percentage.

(k) During the first quarter of State Fiscal Year 2020, the Department of Healthcare of Family Services must convene a technical advisory group consisting of members of all trade associations representing Illinois skilled nursing providers to discuss changes necessary with federal implementation of Medicare's Patient-Driven Payment Model. Implementation of Medicare's Patient-Driven Payment Model shall, by September 1, 2020, end the collection of the MDS data that is necessary to maintain the current RUG-IV Medicaid payment methodology. The technical advisory group must consider a revised reimbursement methodology that takes into account transparency, accountability, actual staffing as reported under the federally required Payroll Based Journal system, changes to the minimum wage, adequacy in coverage of the cost of care, and a quality component that rewards quality improvements.

(l) The Department shall establish per diem add-on payments to improve the quality of care delivered by facilities, including:

(1) Incentive payments determined by facility performance on specified quality measures in an initial amount of $70,000,000. Nothing in this subsection shall be construed to limit the quality of care payments in the aggregate statewide to $70,000,000, and, if quality of care has improved across nursing facilities, the Department shall adjust those add-on payments accordingly. The quality payment methodology described in this

subsection must be used for at least State Fiscal Year 2023. Beginning with the quarter starting July 1, 2023, the Department may add, remove, or change quality metrics and make associated changes to the quality payment methodology as outlined in subparagraph (E). Facilities designated by the Centers for Medicare and Medicaid Services as a special focus facility or a hospital-based nursing home do not qualify for quality payments.

(A) Each quality pool must be distributed by assigning a quality weighted score for each nursing home which is calculated by multiplying the nursing home's quality base period Medicaid days by the nursing home's star rating weight in that period.

(B) Star rating weights are assigned based on the nursing home's star rating for the LTS quality star rating. As used in this subparagraph, "LTS quality star rating" means the long-term stay quality rating for each nursing facility, as assigned by the Centers for Medicare and Medicaid Services under the Five-Star Quality Rating System. The rating is a number ranging from 0 (lowest) to 5 (highest).

(i) Zero-star or one-star rating has a weight of 0.

(ii) Two-star rating has a weight of 0.75.

(iii) Three-star rating has a weight of 1.5.

(iv) Four-star rating has a weight of 2.5.

(v) Five-star rating has a weight of 3.5.

(C) Each nursing home's quality weight score is divided by the sum of all quality weight scores for qualifying nursing homes to determine the proportion of the quality pool to be paid to the nursing home.

(D) The quality pool is no less than $70,000,000 annually or $17,500,000 per quarter. The Department shall publish on its website the estimated payments and the associated weights for each facility 45 days prior to when the initial payments for the quarter are to be paid. The Department shall assign each facility the most recent and applicable quarter's STAR value unless the facility notifies the Department within 15 days of an issue and the facility provides reasonable evidence demonstrating its timely compliance with federal data submission requirements for the quarter of record. If such evidence cannot be provided to the Department, the STAR rating assigned to the facility shall be reduced by one from the prior quarter.

(E) The Department shall review quality metrics used for payment of the quality pool and make recommendations for any associated changes to the methodology for distributing quality pool payments in consultation with associations representing long-term care providers, consumer advocates, organizations representing workers of long-term care facilities, and

payors. The Department may establish, by rule, changes to the methodology for distributing quality pool payments.

(F) The Department shall disburse quality pool payments from the Long-Term Care Provider Fund on a monthly basis in amounts proportional to the total quality pool payment determined for the quarter.

(G) The Department shall publish any changes in the methodology for distributing quality pool payments prior to the beginning of the measurement period or quality base period for any metric added to the distribution's methodology.

(2) Payments based on CNA tenure, promotion, and CNA training for the purpose of increasing CNA compensation. It is the intent of this subsection that payments made in accordance with this paragraph be directly incorporated into increased compensation for CNAs. As used in this paragraph, "CNA" means a certified nursing assistant as that term is described in Section 3-206 of the Nursing Home Care Act, Section 3-206 of the ID/DD Community Care Act, and Section 3-206 of the MC/DD Act. The Department shall establish, by rule, payments to nursing facilities equal to Medicaid's share of the tenure wage increments specified in this paragraph for all reported CNA employee hours compensated according to a posted schedule consisting of increments at least as large as those

specified in this paragraph. The increments are as follows: an additional $1.50 per hour for CNAs with at least one and less than 2 years' experience plus another $1 per hour for each additional year of experience up to a maximum of $6.50 for CNAs with at least 6 years of experience. For purposes of this paragraph, Medicaid's share shall be the ratio determined by paid Medicaid bed days divided by total bed days for the applicable time period used in the calculation. In addition, and additive to any tenure increments paid as specified in this paragraph, the Department shall establish, by rule, payments supporting Medicaid's share of the promotion-based wage increments for CNA employee hours compensated for that promotion with at least a $1.50 hourly increase. Medicaid's share shall be established as it is for the tenure increments described in this paragraph. Qualifying promotions shall be defined by the Department in rules for an expected 10-15% subset of CNAs assigned intermediate, specialized, or added roles such as CNA trainers, CNA scheduling "captains", and CNA specialists for resident conditions like dementia or memory care or behavioral health.

(m) The Department shall work with nursing facility industry representatives to design policies and procedures to permit facilities to address the integrity of data from federal reporting sites used by the Department in setting

facility rates.

(Source: P.A. 102-77, eff. 7-9-21; 102-558, eff. 8-20-21; 102-1035, eff. 5-31-22; 102-1118, eff. 1-18-23; 103-102, Article 40, Section 40-5, eff. 1-1-24; 103-102, Article 50, Section 50-5, eff. 1-1-24; revised 12-15-23.)

ARTICLE 185.

Section 185-5. The Illinois Public Aid Code is amended by changing Section 5-5a.1 as follows:

(305 ILCS 5/5-5a.1)

Sec. 5-5a.1. Telehealth services for persons with intellectual and developmental disabilities. The Department shall file an amendment to the Home and Community-Based Services Waiver Program for Adults with Developmental Disabilities authorized under Section 1915(c) of the Social Security Act to incorporate telehealth services administered by a provider of telehealth services that demonstrates knowledge and experience in providing medical and emergency services for persons with intellectual and developmental disabilities. For dates of service on and after January 1, 2025, the Department shall pay negotiated, agreed upon administrative fees associated with implementing telehealth services for persons with intellectual and developmental disabilities who are receiving Community Integrated Living

Arrangement residential services under the Home and Community-Based Services Waiver Program for Adults with Developmental Disabilities. The implementation of telehealth services shall not impede the choice of any individual receiving waiver-funded services through the Home and Community-Based Services Waiver Program for Adults with Developmental Disabilities to receive in-person health care services at any time. The Department shall ensure individuals enrolled in the waiver, or their guardians, request to opt-in to these services. For individuals who opt in, this service shall be included in the individual's person-centered plan. The use of telehealth services shall not be used for the convenience of staff at any time nor shall it replace primary care physician services. ~~The Department shall pay administrative fees associated with implementing telehealth services for all persons with intellectual and developmental disabilities who are receiving services under the Home and Community Based Services Waiver Program for Adults with Developmental Disabilities.~~

(Source: P.A. 103-102, eff. 7-1-23.)

ARTICLE 190.

Section 190-5. The Pharmacy Practice Act is amended by changing Sections 3 and 9.6 as follows:

(225 ILCS 85/3)

(Section scheduled to be repealed on January 1, 2028)

Sec. 3. Definitions. For the purpose of this Act, except where otherwise limited therein:

(a) "Pharmacy" or "drugstore" means and includes every store, shop, pharmacy department, or other place where pharmacist care is provided by a pharmacist (1) where drugs, medicines, or poisons are dispensed, sold or offered for sale at retail, or displayed for sale at retail; or (2) where prescriptions of physicians, dentists, advanced practice registered nurses, physician assistants, veterinarians, podiatric physicians, or optometrists, within the limits of their licenses, are compounded, filled, or dispensed; or (3) which has upon it or displayed within it, or affixed to or used in connection with it, a sign bearing the word or words "Pharmacist", "Druggist", "Pharmacy", "Pharmaceutical Care", "Apothecary", "Drugstore", "Medicine Store", "Prescriptions", "Drugs", "Dispensary", "Medicines", or any word or words of similar or like import, either in the English language or any other language; or (4) where the characteristic prescription sign (Rx) or similar design is exhibited; or (5) any store, or shop, or other place with respect to which any of the above words, objects, signs or designs are used in any advertisement.

(b) "Drugs" means and includes (1) articles recognized in the official United States Pharmacopoeia/National Formulary

(USP/NF), or any supplement thereto and being intended for and having for their main use the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals, as approved by the United States Food and Drug Administration, but does not include devices or their components, parts, or accessories; and (2) all other articles intended for and having for their main use the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals, as approved by the United States Food and Drug Administration, but does not include devices or their components, parts, or accessories; and (3) articles (other than food) having for their main use and intended to affect the structure or any function of the body of man or other animals; and (4) articles having for their main use and intended for use as a component or any articles specified in clause (1), (2) or (3); but does not include devices or their components, parts or accessories.

(c) "Medicines" means and includes all drugs intended for human or veterinary use approved by the United States Food and Drug Administration.

(d) "Practice of pharmacy" means:

(1) the interpretation and the provision of assistance in the monitoring, evaluation, and implementation of prescription drug orders;

(2) the dispensing of prescription drug orders;

(3) participation in drug and device selection;

(4) drug administration limited to the administration

of oral, topical, injectable, and inhalation as follows:

(A) in the context of patient education on the proper use or delivery of medications;

(B) vaccination of patients 7 years of age and older pursuant to a valid prescription or standing order, by a physician licensed to practice medicine in all its branches, except for vaccinations covered by paragraph (15), upon completion of appropriate training, including how to address contraindications and adverse reactions set forth by rule, with notification to the patient's physician and appropriate record retention, or pursuant to hospital pharmacy and therapeutics committee policies and procedures. Eligible vaccines are those listed on the U.S. Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule, the CDC's Health Information for International Travel, or the U.S. Food and Drug Administration's Vaccines Licensed and Authorized for Use in the United States. As applicable to the State's Medicaid program and other payers, vaccines ordered and administered in accordance with this subsection shall be covered and reimbursed at no less than the rate that the vaccine is reimbursed when ordered and administered by a physician;

(B-5) following the initial administration of long-acting or extended-release form opioid

antagonists by a physician licensed to practice medicine in all its branches, administration of injections of long-acting or extended-release form opioid antagonists for the treatment of substance use disorder, pursuant to a valid prescription by a physician licensed to practice medicine in all its branches, upon completion of appropriate training, including how to address contraindications and adverse reactions, including, but not limited to, respiratory depression and the performance of cardiopulmonary resuscitation, set forth by rule, with notification to the patient's physician and appropriate record retention, or pursuant to hospital pharmacy and therapeutics committee policies and procedures;

(C) administration of injections of alpha-hydroxyprogesterone caproate, pursuant to a valid prescription, by a physician licensed to practice medicine in all its branches, upon completion of appropriate training, including how to address contraindications and adverse reactions set forth by rule, with notification to the patient's physician and appropriate record retention, or pursuant to hospital pharmacy and therapeutics committee policies and procedures; and

(D) administration of injections of long-term antipsychotic medications pursuant to a valid

prescription by a physician licensed to practice medicine in all its branches, upon completion of appropriate training conducted by an Accreditation Council of Pharmaceutical Education accredited provider, including how to address contraindications and adverse reactions set forth by rule, with notification to the patient's physician and appropriate record retention, or pursuant to hospital pharmacy and therapeutics committee policies and procedures.

(5) (blank);

(6) drug regimen review;

(7) drug or drug-related research;

(8) the provision of patient counseling;

(9) the practice of telepharmacy;

(10) the provision of those acts or services necessary to provide pharmacist care;

(11) medication therapy management;

(12) the responsibility for compounding and labeling of drugs and devices (except labeling by a manufacturer, repackager, or distributor of non-prescription drugs and commercially packaged legend drugs and devices), proper and safe storage of drugs and devices, and maintenance of required records;

(13) the assessment and consultation of patients and dispensing of hormonal contraceptives;

(14) the initiation, dispensing, or administration of drugs, laboratory tests, assessments, referrals, and consultations for human immunodeficiency virus pre-exposure prophylaxis and human immunodeficiency virus post-exposure prophylaxis under Section 43.5;

(15) vaccination of patients 7 years of age and older for COVID-19 or influenza subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the United States Food and Drug Administration, pursuant to the following conditions:

(A) the vaccine must be authorized or licensed by the United States Food and Drug Administration;

(B) the vaccine must be ordered and administered according to the Advisory Committee on Immunization Practices standard immunization schedule;

(C) the pharmacist must complete a course of training accredited by the Accreditation Council on Pharmacy Education or a similar health authority or professional body approved by the Division of Professional Regulation;

(D) the pharmacist must have a current certificate in basic cardiopulmonary resuscitation;

(E) the pharmacist must complete, during each State licensing period, a minimum of 2 hours of immunization-related continuing pharmacy education approved by the Accreditation Council on Pharmacy

Education;

(F) the pharmacist must comply with recordkeeping and reporting requirements of the jurisdiction in which the pharmacist administers vaccines, including informing the patient's primary-care provider, when available, and complying with requirements whereby the person administering a vaccine must review the vaccine registry or other vaccination records prior to administering the vaccine; and

(G) the pharmacist must inform the pharmacist's patients who are less than 18 years old, as well as the adult caregiver accompanying the child, of the importance of a well-child visit with a pediatrician or other licensed primary-care provider and must refer patients as appropriate;

(16) the ordering and administration of COVID-19 therapeutics subcutaneously, intramuscularly, or orally with notification to the patient's physician and appropriate record retention or pursuant to hospital pharmacy and therapeutics committee policies and procedures. Eligible therapeutics are those approved, authorized, or licensed by the United States Food and Drug Administration and must be administered subcutaneously, intramuscularly, or orally in accordance with that approval, authorization, or licensing; and

(17) the ordering and administration of <u>point of care</u>

tests, ~~and~~ screenings, and treatments for (i) influenza, (ii) SARS-CoV-2 ~~SARS-COV-2~~, (iii) Group A Streptococcus, (iv) respiratory syncytial virus, (v) adult-stage head louse, and (vi) ~~(iii)~~ health conditions identified by a statewide public health emergency, as defined in the Illinois Emergency Management Agency Act, with notification to the patient's physician, if any, and appropriate record retention or pursuant to hospital pharmacy and therapeutics committee policies and procedures. Eligible tests and screenings are those approved, authorized, or licensed by the United States Food and Drug Administration and must be administered in accordance with that approval, authorization, or licensing.

A pharmacist who orders or administers tests or screenings for health conditions described in this paragraph may use a test that may guide clinical decision-making for the health condition that is waived under the federal Clinical Laboratory Improvement Amendments of 1988 and regulations promulgated thereunder or any established screening procedure that is established under a statewide protocol.

A pharmacist may delegate the administrative and technical tasks of performing a test for the health conditions described in this paragraph to a registered pharmacy technician or student pharmacist acting under the

supervision of the pharmacist.

The testing, screening, and treatment ordered under this paragraph by a pharmacist shall not be denied reimbursement under health benefit plans that are within the scope of the pharmacist's license and shall be covered as if the services or procedures were performed by a physician, an advanced practice registered nurse, or a physician assistant.

A pharmacy benefit manager, health carrier, health benefit plan, or third-party payor shall not discriminate against a pharmacy or a pharmacist with respect to participation referral, reimbursement of a covered service, or indemnification if a pharmacist is acting within the scope of the pharmacist's license and the pharmacy is operating in compliance with all applicable laws and rules.

A pharmacist who performs any of the acts defined as the practice of pharmacy in this State must be actively licensed as a pharmacist under this Act.

(e) "Prescription" means and includes any written, oral, facsimile, or electronically transmitted order for drugs or medical devices, issued by a physician licensed to practice medicine in all its branches, dentist, veterinarian, podiatric physician, or optometrist, within the limits of his or her license, by a physician assistant in accordance with subsection (f) of Section 4, or by an advanced practice

registered nurse in accordance with subsection (g) of Section 4, containing the following: (1) name of the patient; (2) date when prescription was issued; (3) name and strength of drug or description of the medical device prescribed; and (4) quantity; (5) directions for use; (6) prescriber's name, address, and signature; and (7) DEA registration number where required, for controlled substances. The prescription may, but is not required to, list the illness, disease, or condition for which the drug or device is being prescribed. DEA registration numbers shall not be required on inpatient drug orders. A prescription for medication other than controlled substances shall be valid for up to 15 months from the date issued for the purpose of refills, unless the prescription states otherwise.

(f) "Person" means and includes a natural person, partnership, association, corporation, government entity, or any other legal entity.

(g) "Department" means the Department of Financial and Professional Regulation.

(h) "Board of Pharmacy" or "Board" means the State Board of Pharmacy of the Department of Financial and Professional Regulation.

(i) "Secretary" means the Secretary of Financial and Professional Regulation.

(j) "Drug product selection" means the interchange for a prescribed pharmaceutical product in accordance with Section

25 of this Act and Section 3.14 of the Illinois Food, Drug and Cosmetic Act.

(k) "Inpatient drug order" means an order issued by an authorized prescriber for a resident or patient of a facility licensed under the Nursing Home Care Act, the ID/DD Community Care Act, the MC/DD Act, the Specialized Mental Health Rehabilitation Act of 2013, the Hospital Licensing Act, or the University of Illinois Hospital Act, or a facility which is operated by the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities) or the Department of Corrections.

(k-5) "Pharmacist" means an individual health care professional and provider currently licensed by this State to engage in the practice of pharmacy.

(l) "Pharmacist in charge" means the licensed pharmacist whose name appears on a pharmacy license and who is responsible for all aspects of the operation related to the practice of pharmacy.

(m) "Dispense" or "dispensing" means the interpretation, evaluation, and implementation of a prescription drug order, including the preparation and delivery of a drug or device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to or use by a patient in accordance with applicable State and federal laws and regulations. "Dispense" or "dispensing" does not mean the physical delivery to a patient or a patient's

representative in a home or institution by a designee of a pharmacist or by common carrier. "Dispense" or "dispensing" also does not mean the physical delivery of a drug or medical device to a patient or patient's representative by a pharmacist's designee within a pharmacy or drugstore while the pharmacist is on duty and the pharmacy is open.

(n) "Nonresident pharmacy" means a pharmacy that is located in a state, commonwealth, or territory of the United States, other than Illinois, that delivers, dispenses, or distributes, through the United States Postal Service, commercially acceptable parcel delivery service, or other common carrier, to Illinois residents, any substance which requires a prescription.

(o) "Compounding" means the preparation and mixing of components, excluding flavorings, (1) as the result of a prescriber's prescription drug order or initiative based on the prescriber-patient-pharmacist relationship in the course of professional practice or (2) for the purpose of, or incident to, research, teaching, or chemical analysis and not for sale or dispensing. "Compounding" includes the preparation of drugs or devices in anticipation of receiving prescription drug orders based on routine, regularly observed dispensing patterns. Commercially available products may be compounded for dispensing to individual patients only if all of the following conditions are met: (i) the commercial product is not reasonably available from normal distribution channels in

a timely manner to meet the patient's needs and (ii) the prescribing practitioner has requested that the drug be compounded.

(p) (Blank).

(q) (Blank).

(r) "Patient counseling" means the communication between a pharmacist or a student pharmacist under the supervision of a pharmacist and a patient or the patient's representative about the patient's medication or device for the purpose of optimizing proper use of prescription medications or devices. "Patient counseling" may include without limitation (1) obtaining a medication history; (2) acquiring a patient's allergies and health conditions; (3) facilitation of the patient's understanding of the intended use of the medication; (4) proper directions for use; (5) significant potential adverse events; (6) potential food-drug interactions; and (7) the need to be compliant with the medication therapy. A pharmacy technician may only participate in the following aspects of patient counseling under the supervision of a pharmacist: (1) obtaining medication history; (2) providing the offer for counseling by a pharmacist or student pharmacist; and (3) acquiring a patient's allergies and health conditions.

(s) "Patient profiles" or "patient drug therapy record" means the obtaining, recording, and maintenance of patient prescription information, including prescriptions for

controlled substances, and personal information.

(t) (Blank).

(u) "Medical device" or "device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component part or accessory, required under federal law to bear the label "Caution: Federal law requires dispensing by or on the order of a physician". A seller of goods and services who, only for the purpose of retail sales, compounds, sells, rents, or leases medical devices shall not, by reasons thereof, be required to be a licensed pharmacy.

(v) "Unique identifier" means an electronic signature, handwritten signature or initials, thumb print, or other acceptable biometric or electronic identification process as approved by the Department.

(w) "Current usual and customary retail price" means the price that a pharmacy charges to a non-third-party payor.

(x) "Automated pharmacy system" means a mechanical system located within the confines of the pharmacy or remote location that performs operations or activities, other than compounding or administration, relative to storage, packaging, dispensing, or distribution of medication, and which collects, controls, and maintains all transaction information.

(y) "Drug regimen review" means and includes the evaluation of prescription drug orders and patient records for (1) known allergies; (2) drug or potential therapy

contraindications; (3) reasonable dose, duration of use, and route of administration, taking into consideration factors such as age, gender, and contraindications; (4) reasonable directions for use; (5) potential or actual adverse drug reactions; (6) drug-drug interactions; (7) drug-food interactions; (8) drug-disease contraindications; (9) therapeutic duplication; (10) patient laboratory values when authorized and available; (11) proper utilization (including over or under utilization) and optimum therapeutic outcomes; and (12) abuse and misuse.

(z) "Electronically transmitted prescription" means a prescription that is created, recorded, or stored by electronic means; issued and validated with an electronic signature; and transmitted by electronic means directly from the prescriber to a pharmacy. An electronic prescription is not an image of a physical prescription that is transferred by electronic means from computer to computer, facsimile to facsimile, or facsimile to computer.

(aa) "Medication therapy management services" means a distinct service or group of services offered by licensed pharmacists, physicians licensed to practice medicine in all its branches, advanced practice registered nurses authorized in a written agreement with a physician licensed to practice medicine in all its branches, or physician assistants authorized in guidelines by a supervising physician that optimize therapeutic outcomes for individual patients through

improved medication use. In a retail or other non-hospital pharmacy, medication therapy management services shall consist of the evaluation of prescription drug orders and patient medication records to resolve conflicts with the following:

(1) known allergies;

(2) drug or potential therapy contraindications;

(3) reasonable dose, duration of use, and route of administration, taking into consideration factors such as age, gender, and contraindications;

(4) reasonable directions for use;

(5) potential or actual adverse drug reactions;

(6) drug-drug interactions;

(7) drug-food interactions;

(8) drug-disease contraindications;

(9) identification of therapeutic duplication;

(10) patient laboratory values when authorized and available;

(11) proper utilization (including over or under utilization) and optimum therapeutic outcomes; and

(12) drug abuse and misuse.

"Medication therapy management services" includes the following:

(1) documenting the services delivered and communicating the information provided to patients' prescribers within an appropriate time frame, not to exceed 48 hours;

(2) providing patient counseling designed to enhance a patient's understanding and the appropriate use of his or her medications; and

(3) providing information, support services, and resources designed to enhance a patient's adherence with his or her prescribed therapeutic regimens.

"Medication therapy management services" may also include patient care functions authorized by a physician licensed to practice medicine in all its branches for his or her identified patient or groups of patients under specified conditions or limitations in a standing order from the physician.

"Medication therapy management services" in a licensed hospital may also include the following:

(1) reviewing assessments of the patient's health status; and

(2) following protocols of a hospital pharmacy and therapeutics committee with respect to the fulfillment of medication orders.

(bb) "Pharmacist care" means the provision by a pharmacist of medication therapy management services, with or without the dispensing of drugs or devices, intended to achieve outcomes that improve patient health, quality of life, and comfort and enhance patient safety.

(cc) "Protected health information" means individually identifiable health information that, except as otherwise

provided, is:

(1) transmitted by electronic media;

(2) maintained in any medium set forth in the definition of "electronic media" in the federal Health Insurance Portability and Accountability Act; or

(3) transmitted or maintained in any other form or medium.

"Protected health information" does not include individually identifiable health information found in:

(1) education records covered by the federal Family Educational Right and Privacy Act; or

(2) employment records held by a licensee in its role as an employer.

(dd) "Standing order" means a specific order for a patient or group of patients issued by a physician licensed to practice medicine in all its branches in Illinois.

(ee) "Address of record" means the designated address recorded by the Department in the applicant's application file or licensee's license file maintained by the Department's licensure maintenance unit.

(ff) "Home pharmacy" means the location of a pharmacy's primary operations.

(gg) "Email address of record" means the designated email address recorded by the Department in the applicant's application file or the licensee's license file, as maintained by the Department's licensure maintenance unit.

(Source: P.A. 102-16, eff. 6-17-21; 102-103, eff. 1-1-22; 102-558, eff. 8-20-21; 102-813, eff. 5-13-22; 102-1051, eff. 1-1-23; 103-1, eff. 4-27-23.)

(225 ILCS 85/9.6)

Sec. 9.6. Administration of vaccines and therapeutics by registered pharmacy technicians and student pharmacists.

(a) Under the supervision of an appropriately trained pharmacist, a registered pharmacy technician or student pharmacist may administer COVID-19, SARS-CoV-2, respiratory syncytial virus, and influenza vaccines subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the United States Food and Drug Administration, subject to the following conditions:

(1) the vaccination must be ordered by the supervising pharmacist;

(2) the supervising pharmacist must be readily and immediately available to the immunizing pharmacy technician or student pharmacist;

(3) the pharmacy technician or student pharmacist must complete a practical training program that is approved by the Accreditation Council for Pharmacy Education and that includes hands-on injection technique training and training in the recognition and treatment of emergency reactions to vaccines;

(4) the pharmacy technician or student pharmacist must

have a current certificate in basic cardiopulmonary resuscitation;

(5) the pharmacy technician or student pharmacist must complete, during the relevant licensing period, a minimum of 2 hours of immunization-related continuing pharmacy education that is approved by the Accreditation Council for Pharmacy Education;

(6) the supervising pharmacist must comply with all relevant recordkeeping and reporting requirements;

(7) the supervising pharmacist must be responsible for complying with requirements related to reporting adverse events;

(8) the supervising pharmacist must review the vaccine registry or other vaccination records prior to ordering the vaccination to be administered by the pharmacy technician or student pharmacist;

(9) the pharmacy technician or student pharmacist must, if the patient is 18 years of age or younger, inform the patient and the adult caregiver accompanying the patient of the importance of a well-child visit with a pediatrician or other licensed primary-care provider and must refer patients as appropriate;

(10) in the case of a COVID-19 vaccine, the vaccination must be ordered and administered according to the Advisory Committee on Immunization Practices' COVID-19 vaccine recommendations;

(11) in the case of a COVID-19 vaccine, the supervising pharmacist must comply with any applicable requirements or conditions of use as set forth in the Centers for Disease Control and Prevention COVID-19 vaccination provider agreement and any other federal requirements that apply to the administration of COVID-19 vaccines being administered; and

(12) the registered pharmacy technician or student pharmacist and the supervising pharmacist must comply with all other requirements of this Act and the rules adopted thereunder pertaining to the administration of drugs.

(b) Under the supervision of an appropriately trained pharmacist, a registered pharmacy technician or student pharmacist may administer COVID-19 therapeutics subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the United States Food and Drug Administration, subject to the following conditions:

(1) the COVID-19 therapeutic must be authorized, approved or licensed by the United States Food and Drug Administration;

(2) the COVID-19 therapeutic must be administered subcutaneously, intramuscularly, or orally in accordance with the United States Food and Drug Administration approval, authorization, or licensing;

(3) a pharmacy technician or student pharmacist practicing pursuant to this Section must complete a

practical training program that is approved by the Accreditation Council for Pharmacy Education and that includes hands-on injection technique training, clinical evaluation of indications and contraindications of COVID-19 therapeutics training, training in the recognition and treatment of emergency reactions to COVID-19 therapeutics, and any additional training required in the United States Food and Drug Administration approval, authorization, or licensing;

(4) the pharmacy technician or student pharmacist must have a current certificate in basic cardiopulmonary resuscitation;

(5) the pharmacy technician or student pharmacist must comply with any applicable requirements or conditions of use that apply to the administration of COVID-19 therapeutics;

(6) the supervising pharmacist must comply with all relevant recordkeeping and reporting requirements;

(7) the supervising pharmacist must be readily and immediately available to the pharmacy technician or student pharmacist; and

(8) the registered pharmacy technician or student pharmacist and the supervising pharmacist must comply with all other requirements of this Act and the rules adopted thereunder pertaining to the administration of drugs.

(Source: P.A. 103-1, eff. 4-27-23.)

ARTICLE 999.

Section 999-99. Effective date. This Act takes effect upon becoming law.