AN ACT concerning public aid.

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

ARTICLE 1.

Section 1-1. Short title. This Article may be cited as the Wellness Checks in Schools Program Act. References in this Article to "this Act" mean this Article.

Section 1-5. Findings. The General Assembly finds that:

(1) Depression is the most common mental health disorder among American teens and adults, with over 2,800,000 young people between the ages of 12 and 17 experiencing at least one major depressive episode each year, approximately 10-15% of teenagers exhibiting at least one symptom of depression at any time, and roughly 5% of teenagers suffering from major depression at any time. Teenage depression is 2 to 3 times more common in females than in males.

(2) Various biological, psychological, and environmental risk factors may contribute to teenage depression, which can lead to substance and alcohol abuse, social isolation, poor academic and workplace performance, unnecessary risk taking, early pregnancy, and suicide,

which is the second leading cause of death among teenagers. Approximately 20% of teens with depression seriously consider suicide, and one in 12 attempt suicide. Untreated teenage depression can also result in adverse consequences throughout adulthood.

(3) Most teens who experience depression suffer from more than one episode. It is estimated that, although teenage depression is highly treatable through combinations of therapy, individual and group counseling, and certain medications, fewer than one-third of teenagers experiencing depression seek help or treatment.

(4) The proper detection and diagnosis of mental health conditions, including depression, is a key element in reducing the risk of teenage suicide and improving physical and mental health outcomes for young people. It is therefore fitting and appropriate to establish school-based mental health screenings to help identify the symptoms of mental health conditions and facilitate access to appropriate treatment.

Section 1-10. Wellness Checks in Schools Collaborative.

(a) Subject to appropriation, the Department of Healthcare and Family Services shall establish the Wellness Checks in Schools Collaborative for school districts that wish to implement wellness checks to identify students in grades 7 through 12 who are at risk of mental health conditions,

including depression or other mental health issues. The Department shall work with school districts that have a high percentage of students enrolled in Medicaid and a high number of referrals to the State's Crisis and Referral Entry Services (CARES) hotline.

(b) The Collaborative shall focus on the identification of research-based screening tools validated to screen for mental health conditions in adolescents and identification of staff who will be responsible for completion of the screening tool. Nothing in this Act prohibits a school district from using a self-administered screening tool as part of the wellness check. To assist school districts in selecting research-based screening tools to use in their wellness check programs, the Department of Healthcare and Family Services may develop a list of preapproved research-based screening tools that are validated to screen adolescents for mental health concerns and are appropriate for use in a school setting. The list shall be posted on the websites of the Department of Healthcare and Family Services and the State Board of Education.

(c) The Collaborative shall also focus on assisting participating school districts in establishing a referral process for immediate intervention for students who are identified as having a behavioral health issue that requires intervention.

(d) The Department shall publish a public notice regarding the establishment of the Collaborative with school districts

and shall conduct regular meetings with interested school districts.

(e) Subject to appropriation, the Department shall establish and implement a program to provide wellness checks in public schools in accordance with this Section.

ARTICLE 5.

Section 5-5. The Illinois Public Aid Code is amended by changing Section 14-12 as follows:

(305 ILCS 5/14-12)

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

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

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

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

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

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

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

(6) Beginning July 1, 2014 and ending on June 30, 2024, in addition to the statewide-standardized amount,

the Department shall develop an adjustor to adjust the rate of reimbursement for safety-net hospitals defined in Section 5-5e.1 of this Code excluding pediatric hospitals.

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

(7.5) (Blank).

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

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

(10) Beginning July 1, 2018, the statewide-standardized amount for inpatient general acute

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

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

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

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

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

(A) The initial statewide standardized amounts, with the labor portion adjusted by the Calendar Year 2013 Medicare Outpatient Prospective Payment System

wage index with reclassifications, shall be published by the Department on its website no later than 10 calendar days prior to their effective date.

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

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

(4) Beginning July 1, 2018, in addition to the statewide standardized amounts, the Department shall make an add-on payment for outpatient expensive devices and drugs. This add-on payment shall at least apply to claim lines that: (i) are assigned with one of the following EAPGs: 490, 1001 to 1020, and coded with one of the following revenue codes: 0274 to 0276, 0278; or (ii) are assigned with one of the following EAPGs: 430 to 441, 443, 444, 460 to 465, 495, 496, 1090. The add-on payment shall be calculated as follows: the claim line's covered charges multiplied by the hospital's total acute cost to charge ratio, less the claim line's EAPG payment plus $1,000, multiplied by 0.8.

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

(6) Effective for dates of service on or after July 1, 2018, the Department shall establish adjustments to the statewide-standardized amounts for each Critical Access Hospital, as designated by the Department of Public Health in accordance with 42 CFR 485, Subpart F, such that each

Critical Access Hospital's standardized amount for outpatient services shall be increased by the applicable uniform percentage determined pursuant to paragraph (5) of this subsection. It is the intent of the General Assembly that the adjustments required under this paragraph (6) by Public Act 100-1181 shall be applied retroactively to claims for dates of service provided on or after July 1, 2018.

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

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

paragraphs (3) and (4) of this subsection, for all hospitals that are not Critical Access Hospitals, multiplied by 46%.

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

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

(9) Within 60 days after federal approval of the change made to the assessment in Section 5A-2 by this amendatory Act of the 101st General Assembly, the Department shall incorporate into the EAPG system for outpatient services those services performed by hospitals

currently billed through the Non-Institutional Provider billing system.

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

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

(d) Transition period. There shall be a transition period to the reimbursement systems authorized under this Section that shall begin on the effective date of these systems and continue until June 30, 2018, unless extended by rule by the Department. To help provide an orderly and predictable transition to the new reimbursement systems and to preserve and enhance access to the hospital services during this

transition, the Department shall allocate a transitional hospital access pool of at least $290,000,000 annually so that transitional hospital access payments are made to hospitals.

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

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

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

(1) Phase 1. In State fiscal years 2019 through 2020, the Department shall allocate funds from the transitional

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

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

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

(C) If the hospital's Rate Year 2017 Medicaid inpatient utilization rate is less than 25%, the hospital transformation payment shall be equal to 50% of the sum of its transitional hospital access payment

authorized under subsection (d) and any supplemental payment authorized under subsection (f).

(2) Phase 2.

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

(B) Because there are communities in Illinois that experience significant health care disparities due to systemic racism, as recently emphasized by the COVID-19 pandemic, aggravated by social determinants of health and a lack of sufficiently allocated healthcare resources, particularly community-based services, preventive care, obstetric care, chronic disease management, and specialty care, the Department shall establish a health care transformation program that shall be supported by the transformation funding pool. It is the intention of the General Assembly that innovative partnerships funded by the pool must be designed to establish or improve integrated health care delivery systems that will provide significant access to the Medicaid and uninsured populations in their communities, as well as improve health care equity. It is also the intention of the General Assembly that partnerships recognize and address the disparities revealed by the COVID-19 pandemic, as well as the need for post-COVID care. During State fiscal

years 2021 through 2027, the hospital and health care transformation program shall be supported by an annual transformation funding pool of up to $150,000,000, pending federal matching funds, to be allocated during the specified fiscal years for the purpose of facilitating hospital and health care transformation. No disbursement of moneys for transformation projects from the transformation funding pool described under this Section shall be considered an award, a grant, or an expenditure of grant funds. Funding agreements made in accordance with the transformation program shall be considered purchases of care under the Illinois Procurement Code, and funds shall be expended by the Department in a manner that maximizes federal funding to expend the entire allocated amount.

The Department shall convene, within 30 days after the effective date of this amendatory Act of the 101st General Assembly, a workgroup that includes subject matter experts on healthcare disparities and stakeholders from distressed communities, which could be a subcommittee of the Medicaid Advisory Committee, to review and provide recommendations on how Department policy, including health care transformation, can improve health disparities and the impact on communities disproportionately affected by COVID-19. The workgroup shall consider and make

recommendations on the following issues: a community safety-net designation of certain hospitals, racial equity, and a regional partnership to bring additional specialty services to communities.

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

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

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

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

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

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

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

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

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

(F) Entities eligible to be funded.

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

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

(iii) The Department should target the funding in the following ways: $30,000,000 of

transformation funds to projects that are a collaboration between a safety-net hospital, particularly community safety-net hospitals, and other providers and designed to address specific healthcare disparities, $20,000,000 of transformation funds to collaborations between safety-net hospitals and a larger hospital partner that increases specialty care in distressed communities, $30,000,000 of transformation funds to projects that are a collaboration between hospitals and other providers in distressed areas of the State designed to address specific healthcare disparities, $15,000,000 to collaborations between critical access hospitals and other providers designed to address specific healthcare disparities, and $15,000,000 to cross-provider collaborations designed to address specific healthcare disparities, and $5,000,000 to collaborations that focus on workforce development.

(iv) The Department may allocate up to $5,000,000 for planning, racial equity analysis, or consulting resources for the Department or entities without the resources to develop a plan to meet the criteria of this Section. Any contract for consulting services issued by the Department

under this subparagraph shall comply with the provisions of Section 5-45 of the State Officials and Employees Ethics Act. Based on availability of federal funding, the Department may directly procure consulting services or provide funding to the collaboration. The provision of resources under this subparagraph is not a guarantee that a project will be approved.

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

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

(i) A detailed description of how the project

intends to affect the goals outlined in this subsection, describing new interventions, new technology, new structures, and other changes to the healthcare delivery system planned.

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

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

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

(v) A timeline showing the evolution of sites and specific services of the project over a 5-year

period, including services available to the community by site.

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

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

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

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

government.

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

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

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

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

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

(xv) An explanation of how the proposal is designed to increase access to care, including

specialty care based upon the community's needs.

(H) The Department shall evaluate proposals for compliance with the criteria listed under subparagraph (G). Proposals meeting all of the criteria may be eligible for funding with the areas of focus prioritized as described in item (ii) of subparagraph (F). Based on the funds available, the Department may negotiate funding agreements with approved applicants to maximize federal funding. Nothing in this subsection requires that an approved project be funded to the level requested. Agreements shall specify the amount of funding anticipated annually, the methodology of payments, the limit on the number of years such funding may be provided, and the milestones and quality metrics that must be met by the projects in order to continue to receive funding during each year of the program. Agreements shall specify the terms and conditions under which a health care facility that receives funds under a purchase of care agreement and closes in violation of the terms of the agreement must pay an early closure fee no greater than 50% of the funds it received under the agreement, prior to the Health Facilities and Services Review Board considering an application for closure of the facility. Any project that is funded shall be required to provide quarterly written progress reports, in a

form prescribed by the Department, and at a minimum shall include the progress made in achieving any milestones or metrics or Business Enterprise Program commitments in its plan. The Department may reduce or end payments, as set forth in transformation plans, if milestones or metrics or Business Enterprise Program commitments are not achieved. The Department shall seek to make payments from the transformation fund in a manner that is eligible for federal matching funds.

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

(3) (Blank).

(4) Hospital Transformation Review Committee. There is created the Hospital Transformation Review Committee. The Committee shall consist of 14 members. No later than 30

days after March 12, 2018 (the effective date of Public Act 100-581), the 4 legislative leaders shall each appoint 3 members; the Governor shall appoint the Director of Healthcare and Family Services, or his or her designee, as a member; and the Director of Healthcare and Family Services shall appoint one member. Any vacancy shall be filled by the applicable appointing authority within 15 calendar days. The members of the Committee shall select a Chair and a Vice-Chair from among its members, provided that the Chair and Vice-Chair cannot be appointed by the same appointing authority and must be from different political parties. The Chair shall have the authority to establish a meeting schedule and convene meetings of the Committee, and the Vice-Chair shall have the authority to convene meetings in the absence of the Chair. The Committee may establish its own rules with respect to meeting schedule, notice of meetings, and the disclosure of documents; however, the Committee shall not have the power to subpoena individuals or documents and any rules must be approved by 9 of the 14 members. The Committee shall perform the functions described in this Section and advise and consult with the Director in the administration of this Section. In addition to reviewing and approving the policies, procedures, and rules for the hospital and health care transformation program, the Committee shall consider and make recommendations related to qualifying

criteria and payment methodologies related to safety-net hospitals and children's hospitals. Members of the Committee appointed by the legislative leaders shall be subject to the jurisdiction of the Legislative Ethics Commission, not the Executive Ethics Commission, and all requests under the Freedom of Information Act shall be directed to the applicable Freedom of Information officer for the General Assembly. The Department shall provide operational support to the Committee as necessary. The Committee is dissolved on April 1, 2019.

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

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

(g) Notwithstanding subsections (a) through (f) of this Section and notwithstanding the changes authorized under Section 5-5b.1, any updates to the system shall not result in

any diminishment of the overall effective rates of reimbursement as of the implementation date of the new system (July 1, 2014). These updates shall not preclude variations in any individual component of the system or hospital rate variations. Nothing in this Section shall prohibit the Department from increasing the rates of reimbursement or developing payments to ensure access to hospital services. Nothing in this Section shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors, including, but not limited to, the number of individuals in the medical assistance program and the severity of illness of the individuals.

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

(i) Except for subsections (g) and (h) of this Section, the Department shall, pursuant to subsection (c) of Section 5-40 of the Illinois Administrative Procedure Act, provide for presentation at the June 2014 hearing of the Joint Committee on Administrative Rules (JCAR) additional written notice to JCAR of the following rules in order to commence the second notice period for the following rules: rules published in the Illinois Register, rule dated February 21, 2014 at 38 Ill.

Reg. 4559 (Medical Payment), 4628 (Specialized Health Care Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic Related Grouping (DRG) Prospective Payment System (PPS)), and 4977 (Hospital Reimbursement Changes), and published in the Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499 (Specialized Health Care Delivery Systems) and 6505 (Hospital Services).

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

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

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

ARTICLE 10.

Section 10-5. The Illinois Public Aid Code is amended by changing Section 5-18.5 as follows:

(305 ILCS 5/5-18.5)

Sec. 5-18.5. Perinatal doula and evidence-based home visiting services.

(a) As used in this Section:

"Home visiting" means a voluntary, evidence-based strategy used to support pregnant people, infants, and young children and their caregivers to promote infant, child, and maternal health, to foster educational development and school readiness, and to help prevent child abuse and neglect. Home visitors are trained professionals whose visits and activities focus on promoting strong parent-child attachment to foster healthy child development.

"Perinatal doula" means a trained provider who provides regular, voluntary physical, emotional, and educational support, but not medical or midwife care, to pregnant and birthing persons before, during, and after childbirth, otherwise known as the perinatal period.

"Perinatal doula training" means any doula training that focuses on providing support throughout the prenatal, labor and delivery, or postpartum period, and reflects the type of doula care that the doula seeks to provide.

(b) Notwithstanding any other provision of this Article, perinatal doula services and evidence-based home visiting services shall be covered under the medical assistance program, subject to appropriation, for persons who are

otherwise eligible for medical assistance under this Article. Perinatal doula services include regular visits beginning in the prenatal period and continuing into the postnatal period, inclusive of continuous support during labor and delivery, that support healthy pregnancies and positive birth outcomes. Perinatal doula services may be embedded in an existing program, such as evidence-based home visiting. Perinatal doula services provided during the prenatal period may be provided weekly, services provided during the labor and delivery period may be provided for the entire duration of labor and the time immediately following birth, and services provided during the postpartum period may be provided up to 12 months postpartum.

(b-5) Notwithstanding any other provision of this Article, beginning January 1, 2023, licensed certified professional midwife services shall be covered under the medical assistance program, subject to appropriation, for persons who are otherwise eligible for medical assistance under this Article. The Department shall consult with midwives on reimbursement rates for midwifery services.

(c) The Department of Healthcare and Family Services shall adopt rules to administer this Section. In this rulemaking, the Department shall consider the expertise of and consult with doula program experts, doula training providers, practicing doulas, and home visiting experts, along with State agencies implementing perinatal doula services and relevant bodies under the Illinois Early Learning Council. This body of

experts shall inform the Department on the credentials necessary for perinatal doula and home visiting services to be eligible for Medicaid reimbursement and the rate of reimbursement for home visiting and perinatal doula services in the prenatal, labor and delivery, and postpartum periods. Every 2 years, the Department shall assess the rates of reimbursement for perinatal doula and home visiting services and adjust rates accordingly.

(d) The Department shall seek such State plan amendments or waivers as may be necessary to implement this Section and shall secure federal financial participation for expenditures made by the Department in accordance with this Section.

(Source: P.A. 102-4, eff. 4-27-21.)

ARTICLE 15.

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

(305 ILCS 5/5-4) (from Ch. 23, par. 5-4)

Sec. 5-4. Amount and nature of medical assistance.

(a) The amount and nature of medical assistance shall be determined in accordance with the standards, rules, and regulations of the Department of Healthcare and Family Services, with due regard to the requirements and conditions in each case, including contributions available from legally

responsible relatives. However, the amount and nature of such medical assistance shall not be affected by the payment of any grant under the Senior Citizens and Persons with Disabilities Property Tax Relief Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. The amount and nature of medical assistance shall not be affected by the receipt of donations or benefits from fundraisers in cases of serious illness, as long as neither the person nor members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

In determining the income and resources available to the institutionalized spouse and to the community spouse, the Department of Healthcare and Family Services shall follow the procedures established by federal law. If an institutionalized spouse or community spouse refuses to comply with the requirements of Title XIX of the federal Social Security Act and the regulations duly promulgated thereunder by failing to provide the total value of assets, including income and resources, to the extent either the institutionalized spouse or community spouse has an ownership interest in them pursuant to 42 U.S.C. 1396r-5, such refusal may result in the institutionalized spouse being denied eligibility and continuing to remain ineligible for the medical assistance program based on failure to cooperate.

Subject to federal approval, beginning January 1, 2023, the community spouse resource allowance shall be established and maintained as follows: a base amount of $109,560 plus an additional amount of $2,784 added to the base amount each year for a period of 10 years commencing with calendar year 2024 through calendar year 2034. In addition to the base amount and the additional amount shall be any increase each year from the prior year to the maximum resource allowance permitted under Section 1924(f)(2)(A)(ii)(II) of the Social Security Act. Subject to federal approval, beginning January 1, 2034 the community spouse resource allowance shall be established and maintained at the maximum amount permitted under Section 1924(f)(2)(A)(ii)(II) of the Social Security Act, as now or hereafter amended, or an amount set after a fair hearing. Subject to federal approval, beginning January 1, 2023 the ~~the community spouse resource allowance shall be established and maintained at the higher of $109,560 or the minimum level permitted pursuant to Section 1924(f)(2) of the Social Security Act, as now or hereafter amended, or an amount set after a fair hearing, whichever is greater. The~~ monthly maintenance allowance for the community spouse shall be established and maintained at the maximum amount ~~higher of $2,739 per month or the minimum level~~ permitted pursuant to Section 1924(d)(3)(C) of the Social Security Act, as now or hereafter amended, or an amount set after a fair hearing, whichever is greater. Subject to the approval of the Secretary

of the United States Department of Health and Human Services, the provisions of this Section shall be extended to persons who but for the provision of home or community-based services under Section 4.02 of the Illinois Act on the Aging, would require the level of care provided in an institution, as is provided for in federal law.

(b) Spousal support for institutionalized spouses receiving medical assistance.

(i) The Department may seek support for an institutionalized spouse, who has assigned his or her right of support from his or her spouse to the State, from the resources and income available to the community spouse.

(ii) The Department may bring an action in the circuit court to establish support orders or itself establish administrative support orders by any means and procedures authorized in this Code, as applicable, except that the standard and regulations for determining ability to support in Section 10-3 shall not limit the amount of support that may be ordered.

(iii) Proceedings may be initiated to obtain support, or for the recovery of aid granted during the period such support was not provided, or both, for the obtainment of support and the recovery of the aid provided. Proceedings for the recovery of aid may be taken separately or they may be consolidated with actions to obtain support. Such

proceedings may be brought in the name of the person or persons requiring support or may be brought in the name of the Department, as the case requires.

(iv) The orders for the payment of moneys for the support of the person shall be just and equitable and may direct payment thereof for such period or periods of time as the circumstances require, including support for a period before the date the order for support is entered. In no event shall the orders reduce the community spouse resource allowance below the level established in subsection (a) of this Section or an amount set after a fair hearing, whichever is greater, or reduce the monthly maintenance allowance for the community spouse below the level permitted pursuant to subsection (a) of this Section.

(Source: P.A. 98-104, eff. 7-22-13; 99-143, eff. 7-27-15.)

ARTICLE 20.

Section 20-5. The Illinois Public Aid Code is amended by adding Sections 5-5.05d, 5-5.05e, 5-5.05f, 5-5.05g, 5-5.06c, and 5-5.06d as follows:

(305 ILCS 5/5-5.05d new)

Sec. 5-5.05d. Academic detailing for behavioral health providers. The Department shall develop, in collaboration with

associations representing behavioral health providers, a program designed to provide behavioral health providers and providers in academic medical settings who need assistance in caring for patients with severe mental illness or a developmental disability under the medical assistance program with academic detailing and clinical consultation over the phone from a qualified provider on how to best care for the patient. The Department shall include the phone number on its website and notify providers that the service is available. The Department may create an in-person option if adequate staff is available. To the extent practicable, the Department shall build upon this service to address worker shortages and the availability of specialty services.

(305 ILCS 5/5-5.05e new)

Sec. 5-5.05e. Tracking availability of beds for withdrawal management services. The Department of Human Services shall track, or contract with an organization to track, the availability of beds for withdrawal management services that are licensed by the Department and are available to medical assistance beneficiaries. The Department of Human Services shall update the tracking daily and publish the availability of beds online or in another public format.

(305 ILCS 5/5-5.05f new)

Sec. 5-5.05f. Medicaid coverage for peer recovery support

services. On or before January 1, 2023, the Department shall seek approval from the federal Centers for Medicare and Medicaid Services to cover peer recovery support services under the medical assistance program when rendered by certified peer support specialists for the purposes of supporting the recovery of individuals receiving substance use disorder treatment. As used in this Section, "certified peer support specialist" means an individual who:

(1) is a self-identified current or former recipient of substance use disorder services who has the ability to support other individuals diagnosed with a substance use disorder;

(2) is affiliated with a substance use prevention and recovery provider agency that is licensed by the Department of Human Services' Division of Substance Use Prevention and Recovery; and

(A) is certified in accordance with applicable State law to provide peer recovery support services in substance use disorder settings; or

(B) is certified as qualified to furnish peer support services under a certification process consistent with the National Practice Guidelines for Peer Supporters and inclusive of the core competencies identified by the Substance Abuse and Mental Health Services Administration in the Core Competencies for Peer Workers in Behavioral Health Services.

(305 ILCS 5/5-5.05g new)

Sec. 5-5.05g. Alignment of substance use prevention and recovery and mental health policy. The Department and the Department of Human Services shall collaborate to review coverage and billing requirements for substance use prevention and recovery and mental health services with the goal of identifying disparities and streamlining coverage and billing requirements to reduce the administrative burden for providers and medical assistance beneficiaries.

(305 ILCS 5/5-5.06c new)

Sec. 5-5.06c. Access to prenatal and postpartum care. To ensure access to high quality prenatal and postpartum care and to promote continuity of care for pregnant individuals, the Department shall increase the rate for prenatal and postpartum visits to no less than the rate for an adult well visit, including any applicable add-ons, beginning on January 1, 2023. Bundled rates that include prenatal or postpartum visits shall incorporate this increased rate, beginning on January 1, 2023.

(305 ILCS 5/5-5.06d new)

Sec. 5-5.06d. External cephalic version rate. To encourage provider use of external cephalic versions and decrease the rates of caesarean sections in Illinois, the Department shall

evaluate the rate for external cephalic versions and increase the rate by an amount determined by the Department to promote safer birthing options for pregnant individuals, beginning on January 1, 2023.

ARTICLE 25.

Section 25-5. The Illinois Public Aid Code is amended by adding Section 5-5.06e as follows:

(305 ILCS 5/5-5.06e new)

Sec. 5-5.06e. Increased funding for dental services. Beginning January 1, 2023, the amount allocated to fund rates for dental services provided to adults and children under the medical assistance program shall be increased by an approximate amount of $10,000,000.

ARTICLE 30.

Section 30-5. The Illinois Public Aid Code is amended by changing Section 5-5 as follows:

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment

will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant individuals, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and

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

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

persons who are otherwise eligible for assistance under this Article.

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

Notwithstanding any other provision of this Section, all tobacco cessation medications approved by the United States Food and Drug Administration and all individual and group tobacco cessation counseling services and telephone-based counseling services and tobacco cessation medications provided through the Illinois Tobacco Quitline shall be covered under the medical assistance program for persons who are otherwise eligible for assistance under this Article. The Department shall comply with all federal requirements necessary to obtain federal financial participation, as specified in 42 CFR 433.15(b)(7), for telephone-based counseling services provided through the Illinois Tobacco Quitline, including, but not limited to: (i) entering into a memorandum of understanding or interagency agreement with the Department of Public Health, as administrator of the Illinois Tobacco Quitline; and (ii) developing a cost allocation plan for Medicaid-allowable Illinois Tobacco Quitline services in accordance with 45 CFR 95.507. The Department shall submit the memorandum of understanding or interagency agreement, the cost allocation

plan, and all other necessary documentation to the Centers for Medicare and Medicaid Services for review and approval. Coverage under this paragraph shall be contingent upon federal approval.

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

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

Department or the MCE in which the individual is enrolled for payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

On and after July 1, 2018, targeted dental services, as

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

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

On and after January 1, 2022, the Department of Healthcare and Family Services shall administer and regulate a school-based dental program that allows for the out-of-office delivery of preventative dental services in a school setting

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

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

The Department of Healthcare and Family Services must provide coverage and reimbursement for amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of (i) eosinophilic disorders and (ii)

short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

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

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

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

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

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

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

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

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

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

For purposes of this Section:

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

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

"Low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography,

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

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

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

On and after January 1, 2016, the Department shall ensure

that all networks of care for adult clients of the Department include access to at least one breast imaging Center of Imaging Excellence as certified by the American College of Radiology.

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

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.

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 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- or post-adjudicated predictive modeling with an integrated case management system with link analysis. Such a request for information shall not be considered as a request for proposal or as an obligation on the part of the Illinois Department to take any action or acquire any products or services.

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

or replacements of any device or equipment previously authorized for such recipient by the Department. Notwithstanding any provision of Section 5-5f to the contrary, the Department may, by rule, exempt certain replacement wheelchair parts from prior approval and, for wheelchairs, wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

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

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

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

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the

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

The Illinois Department shall develop and operate, in cooperation with other State Departments and agencies and in

compliance with applicable federal laws and regulations, appropriate and effective systems of health care evaluation and programs for monitoring of utilization of health care services and facilities, as it affects persons eligible for medical assistance under this Code.

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

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

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

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

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

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

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

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

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

services associated with kidney transplantation.

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

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

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

(Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; revised 11-18-21.)

ARTICLE 35.

Section 35-5. The Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois is amended by adding Section 2310-434 as follows:

(20 ILCS 2310/2310-434 new)

Sec. 2310-434. Certified Nursing Assistant Intern Program.

(a) As used in this Section, "facility" means a facility licensed by the Department under the Nursing Home Care Act, the MC/DD Act, or the ID/DD Community Care Act or an establishment licensed under the Assisted Living and Shared Housing Act.

(b) The Department shall establish or approve a Certified Nursing Assistant Intern Program to address the increasing need for trained health care workers and provide additional pathways for individuals to become certified nursing assistants. Upon successful completion of the classroom education and on-the-job training requirements of the Program

required under this Section, an individual may provide, at a facility, the patient and resident care services determined under the Program and may perform the procedures listed under subsection (e).

(c) In order to qualify as a certified nursing assistant intern, an individual shall successfully complete at least 8 hours of classroom education on the services and procedures determined under the Program and listed under subsection (e). The classroom education shall be:

(1) taken within the facility where the certified nursing assistant intern will be employed;

(2) proctored by either an advanced practice registered nurse or a registered nurse who holds a bachelor's degree in nursing, has a minimum of 3 years of continuous experience in geriatric care, or is certified as a nursing assistant instructor; and

(3) satisfied by the successful completion of an approved 8-hour online training course or in-person group training.

(d) In order to qualify as a certified nursing assistant intern, an individual shall successfully complete at least 24 hours of on-the-job training in the services and procedures determined under the Program and listed under subsection (e), as follows:

(1) The training program instructor shall be either an advanced practice registered nurse or a registered nurse

who holds a bachelor's degree in nursing, has a minimum of 3 years of continuous experience in geriatric care, or is certified as a nursing assistant instructor.

(2) The training program instructor shall ensure that the student meets the competencies determined under the Program and those listed under subsection (e). The instructor shall document the successful completion or failure of the competencies and any remediation that may allow for the successful completion of the competencies.

(3) All on-the-job training shall be under the direct observation of either an advanced practice registered nurse or a registered nurse who holds a bachelor's degree in nursing, has a minimum of 3 years of continuous experience in geriatric care, or is certified as a nursing assistant instructor.

(4) All on-the-job training shall be conducted at a facility that is licensed by the State of Illinois and that is the facility where the certified nursing assistant intern will be working.

(e) A certified nursing assistant intern shall receive classroom and on-the-job training on how to provide the patient or resident care services and procedures, as determined under the Program, that are required of a certified nursing assistant's performance skills, including, but not limited to, all of the following:

(1) Successful completion and maintenance of active

certification in both first aid and the American Red Cross' courses on cardiopulmonary resuscitation.

(2) Infection control and in-service training required at the facility.

(3) Washing a resident's hands.

(4) Performing oral hygiene on a resident.

(5) Shaving a resident with an electric razor.

(6) Giving a resident a partial bath.

(7) Making a bed that is occupied.

(8) Dressing a resident.

(9) Transferring a resident to a wheelchair using a gait belt or transfer belt.

(10) Ambulating a resident with a gait belt or transfer belt.

(11) Feeding a resident.

(12) Calculating a resident's intake and output.

(13) Placing a resident in a side-lying position.

(14) The Heimlich maneuver.

(f) A certified nursing assistant intern may not perform any of the following on a resident:

(1) Shaving with a nonelectric razor.

(2) Nail care.

(3) Perineal care.

(4) Transfer using a mechanical lift.

(5) Passive range of motion.

(g) A certified nursing assistant intern may only provide

the patient or resident care services and perform the procedures that he or she is deemed qualified to perform that are listed under subsection (e). A certified nursing assistant intern may not provide the procedures excluded under subsection (f).

(h) The Program is subject to the Health Care Worker Background Check Act and the Health Care Worker Background Check Code under 77 Ill. Adm. Code 955. Program participants and personnel shall be included on the Health Care Worker Registry.

(i) A Program participant who has completed the training required under paragraph (5) of subsection (a) of Section 3-206 of the Nursing Home Care Act, has completed the Program from April 21, 2020 through September 18, 2020, and has shown competency in all of the performance skills listed under subsection (e) may be considered a certified nursing assistant intern once the observing advanced practice registered nurse or registered nurse educator has confirmed the Program participant's competency in all of those performance skills.

(j) The requirement under subsection (b) of Section 395.400 of Title 77 of the Illinois Administrative Code that a student must pass a BNATP written competency examination within 12 months after the completion of the BNATP does not apply to a certified nursing assistant intern under this Section. However, upon a Program participant's enrollment in a certified nursing assistant course, the requirement under

subsection (b) of Section 395.400 of Title 77 of the Illinois Administrative Code that a student pass a BNATP written competency examination within 12 months after completion of the BNATP program applies.

(k) A certified nursing assistant intern shall enroll in a certified nursing assistant program within 6 months after completing his or her certified nursing assistant intern training under the Program. The individual may continue to work as a certified nursing assistant intern during his or her certified nursing assistant training. If the scope of work for a nurse assistant in training pursuant to 77 Ill. Adm. Code 300.660 is broader in scope than the work permitted to be performed by a certified nursing assistant intern, then the certified nursing assistant intern enrolled in certified nursing assistant training may perform the work allowed under 77. Ill. Adm. Code 300.660 with written documentation that the certified nursing assistant intern has successfully passed the competencies necessary to perform such skills. The facility shall maintain documentation as to the additional jobs and duties the certified nursing assistant intern is authorized to perform, which shall be made available to the Department upon request. The individual shall receive one hour of credit for every hour employed as a certified nursing assistant intern or as a temporary nurse assistant, not to exceed 30 hours of credit, subject to the approval of an accredited certified nursing assistant training program.

(l) A facility that seeks to train and employ a certified nursing assistant intern at the facility must:

(1) not have received or applied for a registered nurse waiver under Section 3-303.1 of the Nursing Home Care Act, if applicable;

(2) not have been cited for a violation, except a citation for noncompliance with COVID-19 reporting requirements, that has caused severe harm to or the death of a resident within the 2 years prior to employing a certified nursing assistant; for purposes of this paragraph, the revocation of the facility's ability to hire and train a certified nursing assistant intern shall only occur if the underlying federal citation for the revocation remains substantiated following an informal dispute resolution or independent informal dispute resolution;

(3) not have been cited for a violation that resulted in a pattern of certified nursing assistants being removed from the Health Care Worker Registry as a result of resident abuse, neglect, or exploitation within the 2 years prior to employing a certified nursing assistant intern;

(4) if the facility is a skilled nursing facility, meet a minimum staffing ratio of 3.8 hours of nursing and personal care time, as those terms are used in subsection (e) of Section 3-202.05 of the Nursing Home Care Act, each

day for a resident needing skilled care and 2.5 hours of nursing and personal care time each day for a resident needing intermediate care;

(5) not have lost the ability to offer a Nursing Assistant Training and Competency Evaluation Program as a result of an enforcement action;

(6) establish a certified nursing assistant intern mentoring program within the facility for the purposes of increasing education and retention, which must include an experienced certified nurse assistant who has at least 3 years of active employment and is employed by the facility;

(7) not have a monitor or temporary management placed upon the facility by the Department;

(8) not have provided the Department with a notice of imminent closure; and

(9) not have had a termination action initiated by the federal Centers for Medicare and Medicaid Services or the Department for failing to comply with minimum regulatory or licensure requirements.

(m) A facility that does not meet the requirements of subsection (l) shall cease its new employment training, education, or onboarding of any employee under the Program. The facility may resume its new employment training, education, or onboarding of an employee under the Program once the Department determines that the facility is in compliance

with subsection (l).

(n) To study the effectiveness of the Program, the Department shall collect data from participating facilities and publish a report on the extent to which the Program brought individuals into continuing employment as certified nursing assistants in long-term care. Data collected from facilities shall include, but shall not be limited to, the number of certified nursing assistants employed, the number of persons who began participation in the Program, the number of persons who successfully completed the Program, and the number of persons who continue employment in a long-term care service or facility. The report shall be published no later than 6 months after the Program end date determined under subsection (p). A facility participating in the Program shall, twice annually, submit data under this subsection in a manner and time determined by the Department. Failure to submit data under this subsection shall result in suspension of the facility's Program.

(o) The Department may adopt emergency rules in accordance with Section 5-45.21 of the Illinois Administrative Procedure Act.

(p) The Program shall end upon the termination of the Secretary of Health and Human Services' public health emergency declaration for COVID-19 or 3 years after the date that the Program becomes operational, whichever occurs later.

(q) This Section is inoperative 18 months after the

Program end date determined under subsection (p).

Section 35-10. The Assisted Living and Shared Housing Act is amended by adding Section 77 as follows:

(210 ILCS 9/77 new)

Sec. 77. Certified nursing assistant interns.

(a) A certified nursing assistant intern shall report to an establishment's charge nurse or nursing supervisor and may only be assigned duties authorized in Section 2310-434 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois by a supervising nurse.

(b) An establishment shall notify its certified and licensed staff members, in writing, that a certified nursing assistant intern may only provide the services and perform the procedures permitted under Section 2310-434 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois. The notification shall detail which duties may be delegated to a certified nursing assistant intern. The establishment shall establish a policy describing the authorized duties, supervision, and evaluation of certified nursing assistant interns available upon request of the Department and any surveyor.

(c) If an establishment learns that a certified nursing assistant intern is performing work outside the scope of the Certified Nursing Assistant Intern Program's training, the

establishment shall:

(1) stop the certified nursing assistant intern from performing the work;

(2) inspect the work and correct mistakes, if the work performed was done improperly;

(3) assign the work to the appropriate personnel; and

(4) ensure that a thorough assessment of any resident involved in the work performed is completed by a registered nurse.

(d) An establishment that employs a certified nursing assistant intern in violation of this Section shall be subject to civil penalties or fines under subsection (a) of Section 135.

Section 35-15. The Nursing Home Care Act is amended by adding Section 3-613 as follows:

(210 ILCS 45/3-613 new)

Sec. 3-613. Certified nursing assistant interns.

(a) A certified nursing assistant intern shall report to a facility's charge nurse or nursing supervisor and may only be assigned duties authorized in Section 2310-434 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois by a supervising nurse.

(b) A facility shall notify its certified and licensed staff members, in writing, that a certified nursing assistant

intern may only provide the services and perform the procedures permitted under Section 2310-434 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois. The notification shall detail which duties may be delegated to a certified nursing assistant intern. The facility shall establish a policy describing the authorized duties, supervision, and evaluation of certified nursing assistant interns available upon request of the Department and any surveyor.

(c) If a facility learns that a certified nursing assistant intern is performing work outside the scope of the Certified Nursing Assistant Intern Program's training, the facility shall:

(1) stop the certified nursing assistant intern from performing the work;

(2) inspect the work and correct mistakes, if the work performed was done improperly;

(3) assign the work to the appropriate personnel; and

(4) ensure that a thorough assessment of any resident involved in the work performed is completed by a registered nurse.

(d) A facility that employs a certified nursing assistant intern in violation of this Section shall be subject to civil penalties or fines under Section 3-305.

(e) A minimum of 50% of nursing and personal care time shall be provided by a certified nursing assistant, but no

more than 15% of nursing and personal care time may be provided by a certified nursing assistant intern.

Section 35-20. The MC/DD Act is amended by adding Section 3-613 as follows:

(210 ILCS 46/3-613 new)

Sec. 3-613. Certified nursing assistant interns.

(a) A certified nursing assistant intern shall report to a facility's charge nurse or nursing supervisor and may only be assigned duties authorized in Section 2310-434 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois by a supervising nurse.

(b) A facility shall notify its certified and licensed staff members, in writing, that a certified nursing assistant intern may only provide the services and perform the procedures permitted under Section 2310-434 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois. The notification shall detail which duties may be delegated to a certified nursing assistant intern. The facility shall establish a policy describing the authorized duties, supervision, and evaluation of certified nursing assistant interns available upon request of the Department and any surveyor.

(c) If a facility learns that a certified nursing assistant intern is performing work outside the scope of the

Certified Nursing Assistant Intern Program's training, the facility shall:

(1) stop the certified nursing assistant intern from performing the work;

(2) inspect the work and correct mistakes, if the work performed was done improperly;

(3) assign the work to the appropriate personnel; and

(4) ensure that a thorough assessment of any resident involved in the work performed is completed by a registered nurse.

(d) A facility that employs a certified nursing assistant intern in violation of this Section shall be subject to civil penalties or fines under Section 3-305.

Section 35-25. The ID/DD Community Care Act is amended by adding Section 3-613 as follows:

(210 ILCS 47/3-613 new)

Sec. 3-613. Certified nursing assistant interns.

(a) A certified nursing assistant intern shall report to a facility's charge nurse or nursing supervisor and may only be assigned duties authorized in Section 2310-434 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois by a supervising nurse.

(b) A facility shall notify its certified and licensed staff members, in writing, that a certified nursing assistant

intern may only provide the services and perform the procedures permitted under Section 2310-434 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois. The notification shall detail which duties may be delegated to a certified nursing assistant intern. The facility shall establish a policy describing the authorized duties, supervision, and evaluation of certified nursing assistant interns available upon request of the Department and any surveyor.

(c) If a facility learns that a certified nursing assistant intern is performing work outside the scope of the Certified Nursing Assistant Intern Program's training, the facility shall:

(1) stop the certified nursing assistant intern from performing the work;

(2) inspect the work and correct mistakes, if the work performed was done improperly;

(3) assign the work to the appropriate personnel; and

(4) ensure that a thorough assessment of any resident involved in the work performed is completed by a registered nurse.

(d) A facility that employs a certified nursing assistant intern in violation of this Section shall be subject to civil penalties or fines under Section 3-305.

Section 35-30. The Illinois Public Aid Code is amended by

adding Section 5-5.01b as follows:

(305 ILCS 5/5-5.01b new)

Sec. 5-5.01b. Certified Nursing Assistant Intern Program.

(a) The Department shall establish or approve a Certified Nursing Assistant Intern Program to address the increasing need for trained health care workers for the supporting living facilities program established under Section 5-5.01a. Upon successful completion of the classroom education and on-the-job training requirements of the Program under this Section, an individual may provide, at a facility certified under this Act, the patient and resident care services determined under the Program and may perform the procedures listed under subsection (d).

(b) In order to qualify as a certified nursing assistant intern, an individual shall successfully complete at least 8 hours of classroom education on the services and procedures listed under subsection (d). The classroom education shall be:

(1) taken within the facility where the certified nursing assistant intern will be employed;

(2) proctored by either an advanced practice registered nurse or a registered nurse who holds a bachelor's degree in nursing, has a minimum of 3 years of continuous experience in geriatric care, or is certified as a nursing assistant instructor; and

(3) satisfied by the successful completion of an

approved 8-hour online training course or in-person group training.

(c) In order to qualify as a certified nursing assistant intern, an individual shall successfully complete at least 24 hours of on-the-job training in the services and procedures determined under the Program and listed under subsection (d), as follows:

(1) The training program instructor shall be either an advanced practice registered nurse or a registered nurse who holds a bachelor's degree in nursing, has a minimum of 3 years of continuous experience in geriatric care, or is certified as a nursing assistant instructor.

(2) The training program instructor shall ensure that the student meets the competencies determined under the Program and those listed under subsection (d). The instructor shall document the successful completion or failure of the competencies and any remediation that may allow for the successful completion of the competencies.

(3) All on-the-job training shall be under the direct observation of either an advanced practice registered nurse or a registered nurse who holds a bachelor's degree in nursing, has a minimum of 3 years of continuous experience in geriatric care, or is certified as a nursing assistant instructor.

(4) All on-the-job training shall be conducted at a facility that is licensed by the State of Illinois and

that is the facility where the certified nursing assistant intern will be working.

(d) A certified nursing assistant intern shall receive classroom and on-the-job training on how to provide the patient or resident care services and procedures, as determined under the Program, that are required of a certified nursing assistant's performance skills, including, but not limited to, all of the following:

(1) Successful completion and maintenance of active certification in both first aid and the American Red Cross' courses on cardiopulmonary resuscitation.

(2) Infection control and in-service training required at the facility.

(3) Washing a resident's hands.

(4) Performing oral hygiene on a resident.

(5) Shaving a resident with an electric razor.

(6) Giving a resident a partial bath.

(7) Making a bed that is occupied.

(8) Dressing a resident.

(9) Transferring a resident to a wheelchair using a gait belt or transfer belt.

(10) Ambulating a resident with a gait belt or transfer belt.

(11) Feeding a resident.

(12) Calculating a resident's intake and output.

(13) Placing a resident in a side-lying position.

(14) The Heimlich maneuver.

(e) A certified nursing assistant intern may not perform any of the following on a resident:

(1) Shaving with a nonelectric razor.

(2) Nail care.

(3) Perineal care.

(4) Transfer using a mechanical lift.

(5) Passive range of motion.

(f) A certified nursing assistant intern may only provide the patient or resident care services and perform the procedures that he or she is deemed qualified to perform that are listed under subsection (d). A certified nursing assistant intern may not provide the procedures excluded under subsection (e).

(g) A certified nursing assistant intern shall report to a facility's charge nurse or nursing supervisor and may only be assigned duties authorized in this Section by a supervising nurse.

(h) A facility shall notify its certified and licensed staff members, in writing, that a certified nursing assistant intern may only provide the services and perform the procedures listed under subsection (d). The notification shall detail which duties may be delegated to a certified nursing assistant intern.

(i) If a facility learns that a certified nursing assistant intern is performing work outside of the scope of

the Program's training, the facility shall:

(1) stop the certified nursing assistant intern from performing the work;

(2) inspect the work and correct mistakes, if the work performed was done improperly;

(3) assign the work to the appropriate personnel; and

(4) ensure that a thorough assessment of any resident involved in the work performed is completed by a registered nurse.

(j) The Program is subject to the Health Care Worker Background Check Act and the Health Care Worker Background Check Code under 77 Ill. Adm. Code 955. Program participants and personnel shall be included on the Health Care Worker Registry.

(k) A Program participant who has completed the training required under paragraph (5) of subsection (a) of Section 3-206 of the Nursing Home Care Act, has completed the Program from April 21, 2020 through September 18, 2020, and has shown competency in all of the performance skills listed under subsection (d) shall be considered a certified nursing assistant intern.

(l) The requirement under subsection (b) of Section 395.400 of Title 77 of the Illinois Administrative Code that a student must pass a BNATP written competency examination within 12 months after the completion of the BNATP does not apply to a certified nursing assistant intern under this

Section. However, upon a Program participant's enrollment in a certified nursing assistant course, the requirement under subsection (b) of Section 395.400 of Title 77 of the Illinois Administrative Code that a student pass a BNATP written competency examination within 12 months after completion of the BNATP program applies.

(m) A certified nursing assistant intern shall enroll in a certified nursing assistant program within 6 months after completing his or her certified nursing assistant intern training under the Program. The individual may continue to work as a certified nursing assistant intern during his or her certified nursing assistant training. If the scope of work for a nurse assistant in training pursuant to 77 Ill. Adm. Code 300.660 is broader in scope than the work permitted to be performed by a certified nursing assistant intern, then the certified nursing assistant intern enrolled in certified nursing assistant training may perform the work allowed under 77. Ill. Adm. Code 300.660. The individual shall receive one hour of credit for every hour employed as a certified nursing assistant intern or as a temporary nurse assistant, not to exceed 30 hours of credit, subject to the approval of an accredited certified nursing assistant training program.

(n) A facility that seeks to train and employ a certified nursing assistant intern at the facility must:

(1) not have received a substantiated citation, that the facility has the right to the appeal, for a violation

that has caused severe harm to or the death of a resident within the 2 years prior to employing a certified nursing assistant intern; and

(2) establish a certified nursing assistant intern mentoring program within the facility for the purposes of increasing education and retention, which must include an experienced certified nurse assistant who has at least 3 years of active employment and is employed by the facility.

(o) A facility that does not meet the requirements of subsection (n) shall cease its new employment training, education, or onboarding of any employee under the Program. The facility may resume its new employment training, education, or onboarding of an employee under the Program once the Department determines that the facility is in compliance with subsection (n).

(p) To study the effectiveness of the Program, the Department shall collect data from participating facilities and publish a report on the extent to which the Program brought individuals into continuing employment as certified nursing assistants in long-term care. Data collected from facilities shall include, but shall not be limited to, the number of certified nursing assistants employed, the number of persons who began participation in the Program, the number of persons who successfully completed the Program, and the number of persons who continue employment in a long-term care service or

facility. The report shall be published no later than 6 months after the Program end date determined under subsection (r). A facility participating in the Program shall, twice annually, submit data under this subsection in a manner and time determined by the Department. Failure to submit data under this subsection shall result in suspension of the facility's Program.

(q) The Department may adopt emergency rules in accordance with Section 5-45.22 of the Illinois Administrative Procedure Act.

(r) The Program shall end upon the termination of the Secretary of Health and Human Services' public health emergency declaration for COVID-19 or 3 years after the date that the Program becomes operational, whichever occurs later.

(s) This Section is inoperative 18 months after the Program end date determined under subsection (r).

Section 35-35. The Illinois Administrative Procedure Act is amended by adding Sections 5-45.21 and 5-45.22 as follows:

(5 ILCS 100/5-45.21 new)

Sec. 5-45.21. Emergency rulemaking; Certified Nursing Assistant Intern Program; Department of Public Health. To provide for the expeditious and timely implementation of this amendatory Act of the 102nd General Assembly, emergency rules implementing Section 2310-434 of the Department of Public

Health Powers and Duties Law of the Civil Administrative Code of Illinois may be adopted in accordance with Section 5-45 by the Department of Public Health. 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 102nd General Assembly.

(5 ILCS 100/5-45.22 new)

Sec. 5-45.22. Emergency rulemaking; Certified Nursing Assistant Intern Program; Department of Healthcare and Family Services. To provide for the expeditious and timely implementation of this amendatory Act of the 102nd General Assembly, emergency rules implementing Section 5-5.01b 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 102nd General Assembly.

ARTICLE 40.

Section 40-5. The Illinois Public Aid Code is amended by changing Section 11-5.1 and by adding Sections 5-1.6, 5-13.1

and 11-5.5 as follows:

(305 ILCS 5/5-1.6 new)

Sec. 5-1.6. Continuous eligibility; ex parte redeterminations.

(a) By July 1, 2022, the Department of Healthcare and Family Services shall seek a State Plan amendment or any federal waivers necessary to make changes to the medical assistance program. The Department shall apply for federal approval to implement 12 months of continuous eligibility for adults participating in the medical assistance program. The Department shall secure federal financial participation in accordance with this Section for expenditures made by the Department in State Fiscal Year 2023 and every State fiscal year thereafter.

(b) By July 1, 2022, the Department of Healthcare and Family Services shall seek a State Plan amendment or any federal waivers or approvals necessary to make changes to the medical assistance redetermination process for people without any income at the time of redetermination. These changes shall seek to allow all people without income to be considered for ex parte redetermination. If there is no non-income related disqualifying information for medical assistance recipients without any income, then a person without any income shall be redetermined ex parte. Within 60 days after receiving federal approval or guidance, the Department of Healthcare and Family

Services and the Department of Human Services shall make necessary technical and rule changes to implement changes to the redetermination process. The percentage of medical assistance recipients whose eligibility is renewed through the ex parte redetermination process shall be reported monthly by the Department of Healthcare and Family Services on its website in accordance with subsection (d) of Section 11-5.1 of this Code as well as shared in all Medicaid Advisory Committee meetings and Medicaid Advisory Committee Public Education Subcommittee meetings.

(305 ILCS 5/5-13.1 new)

Sec. 5-13.1. Cost-effectiveness waiver, hardship waivers, and making information about waivers more accessible.

(a) It is the intent of the General Assembly to ease the burden of liens and estate recovery for correctly paid benefits for participants, applicants, and their families and heirs, and to make information about waivers more widely available.

(b) The Department shall waive estate recovery under Sections 3-9 and 5-13 where recovery would not be cost-effective, would work an undue hardship, or for any other just reason, and shall make information about waivers and estate recovery easily accessible.

(1) Cost-effectiveness waiver. Subject to federal approval, the Department shall waive any claim against the

first $25,000 of any estate to prevent substantial and unreasonable hardship. The Department shall consider the gross assets in the estate, including, but not limited to, the net value of real estate less mortgages or liens with priority over the Department's claims. The Department may increase the cost-effectiveness threshold in the future.

(2) Undue hardship waiver. The Department may develop additional hardship waiver standards in addition to those already employed, including, but not limited to, waivers aimed at preserving income-producing real property or a modest home as defined by rule.

(3) Accessible information. The Department shall make information about estate recovery and hardship waivers easily accessible. The Department shall maintain information about how to request a hardship waiver on its website in English, Spanish, and the next 4 most commonly used languages, including a short guide and simple form to facilitate requesting hardship exemptions in each language. On an annual basis, the Department shall publicly report on the number of estate recovery cases that are pursued and the number of undue hardship exemptions granted, including demographic data of the deceased beneficiaries where available.

(305 ILCS 5/11-5.1)

Sec. 11-5.1. Eligibility verification. Notwithstanding any

other provision of this Code, with respect to applications for medical assistance provided under Article V of this Code, eligibility shall be determined in a manner that ensures program integrity and complies with federal laws and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By no later than July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility

of recipients at their annual review of eligibility for medical assistance under this Code. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-Medicaid benefits, that is sufficient to make a determination of continued Medicaid eligibility may be reviewed and verified, and subsequent action taken including client notification of continued Medicaid eligibility. The date of client notification establishes the date for subsequent annual Medicaid eligibility reviews. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice a notice of cancellation shall be issued to the recipient and coverage shall end no later than the last day of the

month following the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By no later than July 1, 2011, require verification of Illinois residency.

The Department, with federal approval, may choose to adopt continuous financial eligibility for a full 12 months for adults on Medicaid.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data shall be requested or provided for any new applicant or

current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

(d) As soon as practical if the data is reasonably available, but no later than January 1, 2017, the Department shall compile on a monthly basis data on eligibility redeterminations of beneficiaries of medical assistance provided under Article V of this Code. In addition to the other data required under this subsection, the Department shall compile on a monthly basis data on the percentage of beneficiaries whose eligibility is renewed through ex parte redeterminations as described in subsection (b) of Section 5-1.6 of this Code, subject to federal approval of the changes made in subsection (b) of Section 5-1.6 by this amendatory Act of the 102nd General Assembly. This data shall be posted on the Department's website, and data from prior months shall be retained and available on the Department's website. The data compiled and reported shall include the following:

(1) The total number of redetermination decisions made in a month and, of that total number, the number of decisions to continue or change benefits and the number of

decisions to cancel benefits.

(2) A breakdown of enrollee language preference for the total number of redetermination decisions made in a month and, of that total number, a breakdown of enrollee language preference for the number of decisions to continue or change benefits, and a breakdown of enrollee language preference for the number of decisions to cancel benefits. The language breakdown shall include, at a minimum, English, Spanish, and the next 4 most commonly used languages.

(3) The percentage of cancellation decisions made in a month due to each of the following:

(A) The beneficiary's ineligibility due to excess income.

(B) The beneficiary's ineligibility due to not being an Illinois resident.

(C) The beneficiary's ineligibility due to being deceased.

(D) The beneficiary's request to cancel benefits.

(E) The beneficiary's lack of response after notices mailed to the beneficiary are returned to the Department as undeliverable by the United States Postal Service.

(F) The beneficiary's lack of response to a request for additional information when reliable information in the beneficiary's account, or other

more current information, is unavailable to the Department to make a decision on whether to continue benefits.

(G) Other reasons tracked by the Department for the purpose of ensuring program integrity.

(4) If a vendor is utilized to provide services in support of the Department's redetermination decision process, the total number of redetermination decisions made in a month and, of that total number, the number of decisions to continue or change benefits, and the number of decisions to cancel benefits (i) with the involvement of the vendor and (ii) without the involvement of the vendor.

(5) Of the total number of benefit cancellations in a month, the number of beneficiaries who return from cancellation within one month, the number of beneficiaries who return from cancellation within 2 months, and the number of beneficiaries who return from cancellation within 3 months. Of the number of beneficiaries who return from cancellation within 3 months, the percentage of those cancellations due to each of the reasons listed under paragraph (3) of this subsection.

(e) The Department shall conduct a complete review of the Medicaid redetermination process in order to identify changes that can increase the use of ex parte redetermination processing. This review shall be completed within 90 days

after the effective date of this amendatory Act of the 101st General Assembly. Within 90 days of completion of the review, the Department shall seek written federal approval of policy changes the review recommended and implement once approved. The review shall specifically include, but not be limited to, use of ex parte redeterminations of the following populations:

(1) Recipients of developmental disabilities services.

(2) Recipients of benefits under the State's Aid to the Aged, Blind, or Disabled program.

(3) Recipients of Medicaid long-term care services and supports, including waiver services.

(4) All Modified Adjusted Gross Income (MAGI) populations.

(5) Populations with no verifiable income.

(6) Self-employed people.

The report shall also outline populations and circumstances in which an ex parte redetermination is not a recommended option.

(f) The Department shall explore and implement, as practical and technologically possible, roles that stakeholders outside State agencies can play to assist in expediting eligibility determinations and redeterminations within 24 months after the effective date of this amendatory Act of the 101st General Assembly. Such practical roles to be explored to expedite the eligibility determination processes shall include the implementation of hospital presumptive

eligibility, as authorized by the Patient Protection and Affordable Care Act.

(g) The Department or its designee shall seek federal approval to enhance the reasonable compatibility standard from 5% to 10%.

(h) Reporting. The Department of Healthcare and Family Services and the Department of Human Services shall publish quarterly reports on their progress in implementing policies and practices pursuant to this Section as modified by this amendatory Act of the 101st General Assembly.

(1) The reports shall include, but not be limited to, the following:

(A) Medical application processing, including a breakdown of the number of MAGI, non-MAGI, long-term care, and other medical cases pending for various incremental time frames between 0 to 181 or more days.

(B) Medical redeterminations completed, including: (i) a breakdown of the number of households that were redetermined ex parte and those that were not; (ii) the reasons households were not redetermined ex parte; and (iii) the relative percentages of these reasons.

(C) A narrative discussion on issues identified in the functioning of the State's Integrated Eligibility System and progress on addressing those issues, as well as progress on implementing strategies to address eligibility backlogs, including expanding ex parte

determinations to ensure timely eligibility determinations and renewals.

(2) Initial reports shall be issued within 90 days after the effective date of this amendatory Act of the 101st General Assembly.

(3) All reports shall be published on the Department's website.

(i) It is the determination of the General Assembly that the Department must include seniors and persons with disabilities in ex parte renewals. It is the determination of the General Assembly that the Department must use its asset verification system to assist in the determination of whether an individual's coverage can be renewed using the ex parte process. If a State Plan amendment is required, the Department shall pursue such State Plan amendment by July 1, 2022. Within 60 days after receiving federal approval or guidance, the Department of Healthcare and Family Services and the Department of Human Services shall make necessary technical and rule changes to implement these changes to the redetermination process.

(Source: P.A. 101-209, eff. 8-5-19; 101-649, eff. 7-7-20.)

(305 ILCS 5/11-5.5 new)

Sec. 11-5.5. Streamlining enrollment into the Medicare Savings Program.

(a) The Department shall investigate how to align the

Medicare Part D Low-Income Subsidy and Medicare Savings Program eligibility criteria.

(b) The Department shall issue a report making recommendations on how to streamline enrollment into Medicare Savings Program benefits by July 1, 2022.

(c) Within 90 days after issuing its report, the Department shall seek public feedback on those recommendations and plans.

(d) By July 1, 2023, the Department shall implement the necessary changes to streamline enrollment into the Medicare Savings Program. The Department may adopt any rules necessary to implement the provisions of this paragraph.

(305 ILCS 5/3-10 rep.)

(305 ILCS 5/3-10.1 rep.)

(305 ILCS 5/3-10.2 rep.)

(305 ILCS 5/3-10.3 rep.)

(305 ILCS 5/3-10.4 rep.)

(305 ILCS 5/3-10.5 rep.)

(305 ILCS 5/3-10.6 rep.)

(305 ILCS 5/3-10.7 rep.)

(305 ILCS 5/3-10.8 rep.)

(305 ILCS 5/3-10.9 rep.)

(305 ILCS 5/3-10.10 rep.)

(305 ILCS 5/5-13.5 rep.)

Section 40-10. The Illinois Public Aid Code is amended by

repealing Sections 3-10, 3-10.1, 3-10.2, 3-10.3, 3-10.4, 3-10.5, 3-10.6, 3-10.7, 3-10.8, 3-10.9, and 3-10.10, and 5-13.5.

ARTICLE 45.

Section 45-5. The Illinois Public Aid Code is amended by changing Section 5-5.07 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 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. ~~This Section is inoperative on and after July 1, 2021. Notwithstanding the provision of Public Act 101-209 stating~~

~~that this Section is inoperative on and after July 1, 2020, this Section is operative from July 1, 2020 through July 1, 2023.~~

(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.)

ARTICLE 50.

Section 50-5. The Illinois Public Aid Code is amended by changing Section 5-4.2 and by adding Section 5-30d as follows:

(305 ILCS 5/5-4.2)

Sec. 5-4.2. Ambulance services payments.

(a) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1993, the Illinois Department shall reimburse ambulance service providers at rates calculated in accordance with this Section. It is the intent of the General Assembly to provide adequate reimbursement for ambulance services so as to ensure adequate access to services for recipients of aid under this Article and to provide appropriate incentives to ambulance service providers to provide services in an efficient and cost-effective manner. Thus, it is the intent of the General Assembly that the Illinois Department implement a reimbursement system for ambulance services that, to the

extent practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, is consistent with the payment principles of Medicare. To ensure uniformity between the payment principles of Medicare and Medicaid, the Illinois Department shall follow, to the extent necessary and practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, the statutes, laws, regulations, policies, procedures, principles, definitions, guidelines, and manuals used to determine the amounts paid to ambulance service providers under Title XVIII of the Social Security Act (Medicare).

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

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

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

Public Health pursuant to the Emergency Medical Services (EMS) Systems Act.

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

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

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

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

(e) Beginning with services rendered on or after July 1, 2008, all providers of non-emergency medi-car and service car

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

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

(f) With respect to any policy or program administered by the Department or its agent regarding approval of non-emergency medical transportation by ground ambulance service providers, including, but not limited to, the Non-Emergency Transportation Services Prior Approval Program (NETSPAP), the Department shall establish by rule a process by which ground ambulance service providers of non-emergency medical transportation may appeal any decision by the Department or its agent for which no denial was received prior to the time of transport that either (i) denies a request for approval for payment of non-emergency transportation by means of ground ambulance service or (ii) grants a request for approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than the ground ambulance service provider would have received as compensation for the level of service requested. The rule shall be filed by December 15, 2012 and shall provide that, for any decision rendered by the Department or its agent on or after the date the rule takes effect, the ground ambulance service provider shall have 60 days from the date the decision is received to file an appeal. The rule established by the Department shall be, insofar as is practical, consistent with the Illinois Administrative Procedure Act. The Director's decision on an appeal under this Section shall be a final administrative

decision subject to review under the Administrative Review Law.

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

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

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

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

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

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

after the issuance of the Physician Certification Statement by the Department of Healthcare and Family Services.

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

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

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

(i) On and after July 1, 2018, the Department shall increase the base rate of reimbursement for both base charges and mileage charges for ground ambulance service providers for

medical transportation services provided by means of a ground ambulance to a level not lower than 112% of the base rate in effect as of June 30, 2018.

(Source: P.A. 101-81, eff. 7-12-19; 101-649, eff. 7-7-20; 102-364, eff. 1-1-22; 102-650, eff. 8-27-21; revised 11-8-21.)

(305 ILCS 5/5-30d new)

Sec. 5-30d. Increased funding for transportation services. Beginning no later than January 1, 2023 and subject to federal approval, the amount allocated to fund rates for medi-car, service car, and attendant services provided to adults and children under the medical assistance program shall be increased by an approximate amount of $24,000,000.

ARTICLE 55.

Section 55-5. The Illinois Administrative Procedure Act is amended by adding Section 5-45.23 as follows:

(5 ILCS 100/5-45.23 new)

Sec. 5-45.23. Emergency rulemaking; medical services to noncitizens. To provide for the expeditious and timely implementation of changes made by this amendatory Act of the 102nd General Assembly to Section 12-4.35 of the Illinois Public Aid Code, emergency rules implementing the changes made by this amendatory Act of the 102nd General Assembly to

Section 12-4.35 of the Illinois Public Aid Code may be adopted in accordance with Section 5-45 by the Department of Healthcare and Family Services. 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 102nd General Assembly.

Section 55-10. The Illinois Public Aid Code is amended by changing Section 12-4.35 as follows:

(305 ILCS 5/12-4.35)

Sec. 12-4.35. Medical services for certain noncitizens.

(a) Notwithstanding Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act, the Department of Healthcare and Family Services may provide medical services to noncitizens who have not yet attained 19 years of age and who are not eligible for medical assistance under Article V of this Code or under the Children's Health Insurance Program created by the Children's Health Insurance Program Act due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as

restrictive as the rules for medical assistance under Article V of this Code or the Children's Health Insurance Program created by the Children's Health Insurance Program Act.

(a-5) Notwithstanding Section 1-11 of this Code, the Department of Healthcare and Family Services may provide medical assistance in accordance with Article V of this Code to noncitizens over the age of 65 years of age who are not eligible for medical assistance under Article V of this Code due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code, whose income is at or below 100% of the federal poverty level after deducting the costs of medical or other remedial care, and who would otherwise meet the eligibility requirements in Section 5-2 of this Code. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code.

(a-6) By May 30, 2022, notwithstanding Section 1-11 of this Code, the Department of Healthcare and Family Services may provide medical services to noncitizens 55 years of age through 64 years of age who (i) are not eligible for medical assistance under Article V of this Code due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code and (ii) have income at or below 133% of the federal poverty level plus 5% for the applicable family size as

determined under applicable federal law and regulations. Persons eligible for medical services under Public Act 102-16 ~~this amendatory Act of the 102nd General Assembly~~ shall receive benefits identical to the benefits provided under the Health Benefits Service Package as that term is defined in subsection (m) of Section 5-1.1 of this Code.

(a-7) By July 1, 2022, notwithstanding Section 1-11 of this Code, the Department of Healthcare and Family Services may provide medical services to noncitizens 42 years of age through 54 years of age who (i) are not eligible for medical assistance under Article V of this Code due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code and (ii) have income at or below 133% of the federal poverty level plus 5% for the applicable family size as determined under applicable federal law and regulations. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code. In order to provide for the timely and expeditious implementation of this subsection, the Department may adopt rules necessary to establish and implement this subsection through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of the Illinois Administrative Procedure Act, the General Assembly

finds that the adoption of rules to implement this subsection is deemed necessary for the public interest, safety, and welfare.

(a-10) Notwithstanding the provisions of Section 1-11, the Department shall cover immunosuppressive drugs and related services associated with post-kidney transplant management, excluding long-term care costs, for noncitizens who: (i) are not eligible for comprehensive medical benefits; (ii) meet the residency requirements of Section 5-3; and (iii) would meet the financial eligibility requirements of Section 5-2.

(b) The Department is authorized to take any action that would not otherwise be prohibited by applicable law, including, without limitation, cessation or limitation of enrollment, reduction of available medical services, and changing standards for eligibility, that is deemed necessary by the Department during a State fiscal year to assure that payments under this Section do not exceed available funds.

(c) (Blank).

(d) (Blank).

(Source: P.A. 101-636, eff. 6-10-20; 102-16, eff. 6-17-21; 102-43, Article 25, Section 25-15, eff. 7-6-21; 102-43, Article 45, Section 45-5, eff. 7-6-21; revised 7-15-21.)

ARTICLE 999.

Section 999-99. Effective date. This Act takes effect upon becoming law.