

**102ND GENERAL ASSEMBLY****State of Illinois****2021 and 2022****SB2384**

Introduced 2/26/2021, by Sen. Laura Fine

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Public Aid Code. Provides that the medical assistance program shall cover community-based pediatric palliative care from a trained interdisciplinary team. Amends the Pediatric Palliative Care Act. Repeals a provision that made the Act inoperative on and after July 1, 2012. Requires the Department of Healthcare and Family Services to develop a pediatric palliative care program (rather than a pediatric palliative care pilot program) under which a qualifying child may receive community-based pediatric palliative care from a trained interdisciplinary team and may also choose to continue to pursue aggressive curative or disease-directed treatments for a serious (rather than a potentially life-limiting) illness under the benefits available under the Illinois Public Aid Code. Defines a qualifying child to be a person under the age of 19 (rather than 18) who is enrolled in the medical assistance program and suffers from a serious illness (rather than a potentially life-limiting medical condition). Contains provisions concerning a State Plan amendment; prohibited Department rules; pediatric interdisciplinary teams; reimbursable services offered under the pediatric palliative care program; standards for and technical assistance to managed care organizations; reporting requirements; criteria a case manager must meet for demonstrated expertise in pediatric palliative care; and other matters.

LRB102 16996 KTG 22416 b

FISCAL NOTE ACT
MAY APPLY**A BILL FOR**

1 AN ACT concerning public aid.

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

4 Section 1. Amends the Illinois Public Aid Code is amended
5 by changing Section 5-5 as follows:

6 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

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

1 laws of this State. The term "any other type of remedial care"
2 shall include nursing care and nursing home service for
3 persons who rely on treatment by spiritual means alone through
4 prayer for healing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 The Illinois Department shall authorize the provision of,
21 and shall authorize payment for, screening by low-dose
22 mammography for the presence of occult breast cancer for women
23 35 years of age or older who are eligible for medical
24 assistance under this Article, as follows:

25 (A) A baseline mammogram for women 35 to 39 years of
26 age.

1 (B) An annual mammogram for women 40 years of age or
2 older.

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

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

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

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

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

1 U.S.C. 223).

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

6 For purposes of this Section:

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

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

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

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

25 If, at any time, the Secretary of the United States
26 Department of Health and Human Services, or its successor

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 The Illinois Department, in cooperation with the

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

8 Neither the Department of Healthcare and Family Services
9 nor the Department of Human Services shall sanction the
10 recipient solely on the basis of her substance abuse.

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

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

1 Partnerships. Nothing in this Section shall be construed to
2 require that the sponsor organization be a medical
3 organization.

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

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

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

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

26 Medical providers shall be required to meet certain

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

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

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

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

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

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

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

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

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

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

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

23 Enrollment of a vendor shall be subject to a provisional
24 period and shall be conditional for one year. During the
25 period of conditional enrollment, the Department may terminate
26 the vendor's eligibility to participate in, or may disenroll

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

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

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

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

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

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

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

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

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

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

1 for claims payments.

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

9 In the case of long term care facilities, within 45
10 calendar days of receipt by the facility of required
11 prescreening information, new admissions with associated
12 admission documents shall be submitted through the Medical
13 Electronic Data Interchange (MEDI) or the Recipient
14 Eligibility Verification (REV) System or shall be submitted
15 directly to the Department of Human Services using required
16 admission forms. Effective September 1, 2014, admission
17 documents, including all prescreening information, must be
18 submitted through MEDI or REV. Confirmation numbers assigned
19 to an accepted transaction shall be retained by a facility to
20 verify timely submittal. Once an admission transaction has
21 been completed, all resubmitted claims following prior
22 rejection are subject to receipt no later than 180 days after
23 the admission transaction has been completed.

24 Claims that are not submitted and received in compliance
25 with the foregoing requirements shall not be eligible for
26 payment under the medical assistance program, and the State

1 shall have no liability for payment of those claims.

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

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

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

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

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

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

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

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

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

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

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

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

13 The Illinois Department shall report annually to the
14 General Assembly, no later than the second Friday in April of
15 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

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

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

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

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

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

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

1 Section, "opioid antagonist" means a drug that binds to opioid
2 receptors and blocks or inhibits the effect of opioids acting
3 on those receptors, including, but not limited to, naloxone
4 hydrochloride or any other similarly acting drug approved by
5 the U.S. Food and Drug Administration.

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

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

26 Notwithstanding any other provision of this Code,

1 community-based pediatric palliative care from a trained
2 interdisciplinary team shall be covered under the medical
3 assistance program as provided in Section 15 of the Pediatric
4 Palliative Care Act.

5 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
6 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
7 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
8 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
9 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
10 1-1-20; revised 9-18-19.)

11 Section 5. The Pediatric Palliative Care Act is amended by
12 changing Sections 5, 10, 15, 20, 25, 30, 35, 40, and 45 and by
13 adding Section 37 as follows:

14 (305 ILCS 60/5)

15 Sec. 5. Legislative findings. The General Assembly finds
16 as follows:

17 (1) Each year, approximately 1,500 ~~1,185~~ Illinois
18 children are diagnosed with a serious illness ~~potentially~~
19 ~~life-limiting illness.~~

20 (2) There are many barriers to the provision of
21 pediatric palliative services, the most significant of
22 which include the following: (i) challenges in predicting
23 life expectancy; (ii) the reluctance of families and
24 professionals to acknowledge a child's incurable

1 condition; and (iii) the lack of an appropriate,
2 pediatric-focused reimbursement structure leading to
3 insufficient community-based resources.

4 (3) Community-based pediatric palliative services have
5 been shown to keep children out of the hospital by
6 managing many symptoms in the home setting, thereby
7 improving childhood quality of life while maintaining
8 budget neutrality. ~~It is tremendously difficult for~~
9 ~~physicians to prognosticate pediatric life expectancy due~~
10 ~~to the resiliency of children. In addition, parents are~~
11 ~~rarely prepared to cease curative efforts in order to~~
12 ~~receive hospice or palliative care. Community-based~~
13 ~~pediatric palliative services, however, keep children out~~
14 ~~of the hospital by managing many symptoms in the home~~
15 ~~setting, thereby improving childhood quality of life while~~
16 ~~maintaining budget neutrality.~~

17 ~~(4) Pediatric palliative programming can, and should,~~
18 ~~be administered in a cost neutral fashion. Community based~~
19 ~~pediatric palliative care allows for children and families~~
20 ~~to receive pain and symptom management and psychosocial~~
21 ~~support in the comfort of the home setting, thereby~~
22 ~~avoiding excess spending for emergency room visits and~~
23 ~~certain hospitals. The National Hospice and Palliative~~
24 ~~Care Organization's pediatric task force reported during~~
25 ~~2001 that the average cost per child per year, cared for~~
26 ~~primarily at home, receiving comprehensive palliative and~~

1 ~~life prolonging services concurrently, is \$16,177,~~
2 ~~significantly less than the \$19,000 to \$48,000 per child~~
3 ~~per year when palliative programs are not utilized.~~

4 (Source: P.A. 96-1078, eff. 7-16-10.)

5 (305 ILCS 60/10)

6 Sec. 10. Definitions ~~Definition~~. In this Act: 7

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

9 "Palliative care" means care focused on expert assessment
10 and management of pain and other symptoms, assessment and
11 support of caregiver needs, and coordination of care.
12 Palliative care attends to the physical, functional,
13 psychological, practical, and spiritual consequences of a
14 serious illness. It is a person-centered and family-centered
15 approach to care, providing people living with serious illness
16 relief from the symptoms and stress of an illness. Through
17 early integration into the care plan for the seriously ill,
18 palliative care improves quality of life for the patient and
19 the family. Palliative care can be offered in all care
20 settings and at any stage in a serious illness through
21 collaboration of many types of care providers.

22 "Serious illness" means a health condition that carries a
23 high risk of mortality and either negatively impacts a
24 person's daily function or quality of life or excessively
25 strains their caregiver.

1 (Source: P.A. 96-1078, eff. 7-16-10.)

2 (305 ILCS 60/15)

3 Sec. 15. Pediatric palliative care ~~pilot~~ program. The
4 Department shall develop a pediatric palliative care ~~pilot~~
5 program, and the medical assistance program established under
6 Article V of the Illinois Public Aid Code shall cover ~~under~~
7 ~~which a qualifying child as defined in Section 25 may receive~~
8 community-based pediatric palliative care from a trained
9 interdisciplinary team, as an added benefit under which a
10 qualifying child, as defined in Section 25, may also choose to
11 continue ~~while continuing to pursue aggressive curative or~~
12 disease-directed treatments for a serious ~~potentially~~
13 ~~life-limiting~~ illness under the benefits available under
14 Article V of the Illinois Public Aid Code.

15 (Source: P.A. 96-1078, eff. 7-16-10.)

16 (305 ILCS 60/20)

17 Sec. 20. ~~Federal waiver or~~ State Plan amendment. If
18 applicable, the ~~The~~ Department shall submit the necessary
19 application to the federal Centers for Medicare and Medicaid
20 Services for a ~~waiver or~~ State Plan amendment to implement the
21 ~~pilot~~ program described in this Act. ~~If the application is in~~
22 ~~the form of a State Plan amendment, the State Plan amendment~~
23 ~~shall be filed prior to December 31, 2010. If the Department~~
24 ~~does not submit a State Plan amendment prior to December 31,~~

1 ~~2010, the pilot program shall be created utilizing a waiver~~
2 ~~authority. The waiver request shall be included in any~~
3 ~~appropriate waiver application renewal submitted prior to~~
4 ~~December 31, 2011, or shall be submitted as an independent~~
5 ~~1915(c) Home and Community Based Medicaid Waiver within that~~
6 ~~same time period.~~ After federal approval is secured, the
7 Department shall implement the ~~waiver or~~ State Plan amendment
8 within 12 months of the date of approval. The Department shall
9 not draft any rules in contravention of this timetable for
10 program development and implementation. ~~By federal~~
11 ~~requirement, the application for a 1915 (c) Medicaid waiver~~
12 ~~program must demonstrate cost neutrality per the formula laid~~
13 ~~out by the Centers for Medicare and Medicaid Services. The~~
14 ~~Department shall not draft any rules in contravention of this~~
15 ~~timetable for pilot program development and implementation.~~
16 ~~This pilot program shall be implemented only to the extent~~
17 ~~that federal financial participation is available.~~

18 (Source: P.A. 96-1078, eff. 7-16-10.)

19 (305 ILCS 60/25)

20 Sec. 25. Qualifying child.

21 (a) For the purposes of this Act, a qualifying child is a
22 person under 19 ~~18~~ years of age who is enrolled in the medical
23 assistance program under Article V of the Illinois Public Aid
24 Code and suffers from a serious illness ~~potentially~~
25 ~~life limiting medical condition~~, as defined in subsection (b).

1 A child who is enrolled in the ~~pilot~~ program prior to the age
2 19 ~~18~~ may continue to receive services under the ~~pilot~~ program
3 until the day before his or her twenty-first birthday.

4 (b) The Department, in consultation with interested
5 stakeholders, shall determine the serious illnesses
6 ~~potentially life limiting medical conditions~~ that render a
7 pediatric medical assistance recipient eligible for the ~~pilot~~
8 program under this Act. Such serious illnesses ~~medical~~
9 ~~conditions~~ shall include, but need not be limited to, the
10 following:

11 (1) Cancer (i) for which there is no known effective
12 treatment, (ii) that does not respond to conventional
13 protocol, (iii) that has progressed to an advanced stage,
14 or (iv) where toxicities or other complications limit
15 ~~prohibit~~ the administration of curative therapies.

16 (2) End-stage lung disease, including but not limited
17 to cystic fibrosis, that results in dependence on
18 technology, such as mechanical ventilation.

19 (3) Severe neurological conditions, including, but not
20 limited to, hypoxic ischemic encephalopathy, acute brain
21 injury, brain infections and inflammatory diseases, or
22 irreversible severe alteration of mental status, with one
23 of the following co-morbidities: (i) intractable seizures
24 or (ii) brainstem failure to control breathing or other
25 automatic physiologic functions.

26 (4) Degenerative neuromuscular conditions, including,

1 but not limited to, spinal muscular atrophy, Type I or II,
2 or Duchenne Muscular Dystrophy, requiring technological
3 support.

4 (5) Genetic syndromes, such as , but not limited to,
5 Trisomy 13 or 18, where the child has substantial
6 neurocognitive disability ~~(i) it is more likely than not~~
7 ~~that the child will not live past 2 years of age or (ii)~~
8 ~~the child is severely compromised~~ with no expectation of
9 long-term survival.

10 (6) Congenital or acquired end-stage heart disease,
11 ~~including but not limited to the following: (i) single~~
12 ~~ventricle disorders, including hypoplastic left heart~~
13 ~~syndrome; (ii) total anomalous pulmonary venous return,~~
14 ~~not suitable for curative surgical treatment; and (iii)~~
15 ~~heart muscle disorders (cardiomyopathies)~~ without adequate
16 medical or surgical treatments available.

17 (7) End-stage liver disease where (i) transplant is
18 not a viable option or (ii) transplant rejection or
19 failure has occurred.

20 (8) End-stage kidney failure where (i) transplant is
21 not a viable option or (ii) transplant rejection or
22 failure has occurred.

23 (9) Metabolic or biochemical disorders, including, but
24 not limited to, mitochondrial disease, leukodystrophies,
25 Tay-Sachs disease, or Lesch-Nyhan syndrome where (i) no
26 suitable therapies exist or (ii) available treatments,

1 including stem cell ("bone marrow") transplant, have
2 failed.

3 (10) Congenital or acquired diseases of the
4 gastrointestinal system, such as "short bowel syndrome",
5 where (i) transplant is not a viable option or (ii)
6 transplant rejection or failure has occurred.

7 (11) Congenital skin disorders, including but not
8 limited to epidermolysis bullosa, where no suitable
9 treatment exists.

10 (12) Any other serious illness that the Department
11 determines to be appropriate.

12 The definition of a serious illness ~~life-limiting medical~~
13 ~~condition~~ shall not include a definitive time period due to
14 the difficulty and challenges of prognosticating life
15 expectancy in children.

16 (Source: P.A. 96-1078, eff. 7-16-10.)

17 (305 ILCS 60/30)

18 Sec. 30. Authorized providers. Providers authorized to
19 deliver services under the ~~pilot waiver~~ program shall include
20 licensed hospice agencies or home health agencies licensed to
21 provide hospice care or entities with demonstrated expertise
22 in pediatric palliative care and will be subject to further
23 criteria developed by the Department, in consultation with
24 interested stakeholders, for provider participation. At a
25 minimum, the participating provider must house a pediatric

1 interdisciplinary team that includes: (i) a physician, acting
2 as the program medical director, who is board certified or
3 board eligible in pediatrics or hospice and palliative
4 medicine; (ii) a registered nurse; and (iii) a licensed social
5 worker with a background in pediatric care ~~a pediatric medical~~
6 ~~director, a nurse, and a licensed social worker.~~ All members
7 of the pediatric interdisciplinary team must meet criteria the
8 Department may establish by rule, including demonstrated
9 expertise in pediatric palliative care. ~~submit to the~~
10 ~~Department proof of pediatric End of Life Nursing Education~~
11 ~~Curriculum (Pediatric ELNEC Training) or an equivalent.~~
12 (Source: P.A. 96-1078, eff. 7-16-10.)

13 (305 ILCS 60/35)

14 Sec. 35. Interdisciplinary team; services. ~~The Subject to~~
15 ~~federal approval for matching funds, the~~ reimbursable services
16 offered under the ~~pilot~~ program shall be provided by an
17 interdisciplinary team, operating under the direction of a
18 pediatric medical director, and shall include, but not be
19 limited to, the following:

20 (1) Nursing ~~Pediatric nursing~~ for pain and symptom
21 management.

22 (2) Expressive therapies (music or ~~and~~ art therapies)
23 for age-appropriate counseling.

24 (3) Client and family counseling (provided by a
25 licensed social worker, licensed counselor, child life

1 specialist, or non-denominational chaplain or spiritual
2 counselor).

3 (4) Respite care.

4 (5) Bereavement services.

5 (6) Case management.

6 (7) Any other services that the Department determines
7 to be appropriate.

8 (Source: P.A. 96-1078, eff. 7-16-10.)

9 (305 ILCS 60/37 new)

10 Sec. 37. Medical assistance program standards for
11 pediatric palliative care services. The Department, in
12 consultation with interested stakeholders, shall establish
13 standards for the provision of pediatric palliative care
14 services under the medical assistance program under Article V
15 of the Illinois Public Aid Code. The Department shall
16 establish standards for and provide technical assistance to
17 managed care organizations, as defined in Section 5-30.1 of
18 the Illinois Public Aid Code, to ensure the delivery of
19 pediatric palliative care services to eligible recipients of
20 medical assistance.

21 (305 ILCS 60/40)

22 Sec. 40. Administration.

23 (a) The Department shall oversee the administration of the
24 ~~pilot~~ program. The Department, in consultation with interested

1 stakeholders, shall determine the appropriate process for
2 review of referrals and enrollment of qualifying participants.

3 (b) The Department shall appoint an individual or entity
4 to serve as case manager or an alternative position to assess
5 level-of-care and target-population criteria for the ~~pilot~~
6 program. The Department shall ensure that the individual or
7 entity meets the criteria for demonstrated expertise in
8 pediatric palliative care that the Department, in consultation
9 with interested stakeholders, may establish by rule ~~receives~~
10 ~~pediatric End of Life Nursing Education Curriculum (Pediatric~~
11 ~~ELNEC Training) or an equivalent to become familiarized with~~
12 ~~the unique needs and difficulties facing this population.~~ The
13 process for review of referrals and enrollment of qualifying
14 participants shall not include unnecessary delays and shall
15 reflect the fact that treatment of pain and other distressing
16 symptoms represents an urgent need for children with a serious
17 illness ~~life limiting medical conditions.~~ The process shall
18 also acknowledge that children with a serious illness
19 ~~life limiting medical conditions~~ and their families require
20 holistic and seamless care.

21 (Source: P.A. 96-1078, eff. 7-16-10.)

22 (305 ILCS 60/45)

23 Sec. 45. Report. ~~Period of pilot program.~~ After the
24 program has been in place for 3 years, the Department shall
25 prepare a report for the General Assembly concerning the

1 program's outcomes effectiveness and shall also make
2 recommendations for program improvement, including, but not
3 limited to, the appropriateness of those serious illnesses
4 that render a pediatric medical assistance recipient eligible
5 for the program as defined in subsection (b) of Section 25 and
6 the necessary services needed to ensure high-quality care for
7 children and their families.

8 ~~(a) The program implemented under this Act shall be~~
9 ~~considered a pilot program for 3 years following the date of~~
10 ~~program implementation or, if the pilot program is created~~
11 ~~utilizing a waiver authority, until the waiver that includes~~
12 ~~the services provided under the program undergoes the~~
13 ~~federally mandated renewal process.~~

14 ~~(b) During the period of time that the waiver program is~~
15 ~~considered a pilot program, pediatric palliative care shall be~~
16 ~~included in the issues reviewed by the Hospice and Palliative~~
17 ~~Care Advisory Board. The Board shall make recommendations~~
18 ~~regarding changes or improvements to the program, including~~
19 ~~but not limited to advisement on potential expansion of the~~
20 ~~potentially life-limiting medical conditions as defined in~~
21 ~~subsection (b) of Section 25.~~

22 ~~(c) At the end of the 3-year pilot program, the Department~~
23 ~~shall prepare a report for the General Assembly concerning the~~
24 ~~program's outcomes effectiveness and shall also make~~
25 ~~recommendations for program improvement, including, but not~~
26 ~~limited to, the appropriateness of the potentially~~

1 ~~life limiting medical conditions as defined in subsection (b)~~
2 ~~of Section 25.~~

3 (Source: P.A. 96-1078, eff. 7-16-10.)

4 (305 ILCS 60/3 rep.)

5 Section 10. The Pediatric Palliative Care Act is amended
6 by repealing Section 3.

1 INDEX

2 Statutes amended in order of appearance

3 305 ILCS 5/5-5 from Ch. 23, par. 5-5

4 305 ILCS 60/5

5 305 ILCS 60/10

6 305 ILCS 60/15

7 305 ILCS 60/20

8 305 ILCS 60/25

9 305 ILCS 60/30

10 305 ILCS 60/35

11 305 ILCS 60/37 new

12 305 ILCS 60/40

13 305 ILCS 60/45

14 305 ILCS 60/3 rep.