



Sen. Ann Gillespie

Filed: 4/7/2022

10200HB4343sam001

LRB102 22609 KTG 38977 a

1 AMENDMENT TO HOUSE BILL 4343

2 AMENDMENT NO. _____. Amend House Bill 4343 by replacing
3 everything after the enacting clause with the following:

4 "ARTICLE 1.

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

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

9 (1) Depression is the most common mental health
10 disorder among American teens and adults, with over
11 2,800,000 young people between the ages of 12 and 17
12 experiencing at least one major depressive episode each
13 year, approximately 10-15% of teenagers exhibiting at
14 least one symptom of depression at any time, and roughly
15 5% of teenagers suffering from major depression at any

1 time. Teenage depression is 2 to 3 times more common in
2 females than in males.

3 (2) Various biological, psychological, and
4 environmental risk factors may contribute to teenage
5 depression, which can lead to substance and alcohol abuse,
6 social isolation, poor academic and workplace performance,
7 unnecessary risk taking, early pregnancy, and suicide,
8 which is the second leading cause of death among
9 teenagers. Approximately 20% of teens with depression
10 seriously consider suicide, and one in 12 attempt suicide.
11 Untreated teenage depression can also result in adverse
12 consequences throughout adulthood.

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

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

1 Section 1-10. Wellness Checks in Schools Collaborative.

2 (a) Subject to appropriation, the Department of Healthcare
3 and Family Services shall establish the Wellness Checks in
4 Schools Collaborative for school districts that wish to
5 implement wellness checks to identify students in grades 7
6 through 12 who are at risk of mental health conditions,
7 including depression or other mental health issues. The
8 Department shall work with school districts that have a high
9 percentage of students enrolled in Medicaid and a high number
10 of referrals to the State's Crisis and Referral Entry Services
11 (CARES) hotline.

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

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

6 (d) The Department shall publish a public notice regarding
7 the establishment of the Collaborative with school districts
8 and shall conduct regular meetings with interested school
9 districts.

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

13 ARTICLE 5.

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

16 (305 ILCS 5/14-12)

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

20 (a) Inpatient hospital services. Effective for discharges
21 on and after July 1, 2014, reimbursement for inpatient general
22 acute care services shall utilize the All Patient Refined
23 Diagnosis Related Grouping (APR-DRG) software, version 30,

1 distributed by 3MTM Health Information System.

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

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

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

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

26 (5) The Department shall define those hospitals or

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

6 (6) Beginning July 1, 2014 and ending on June 30,
7 2024, in addition to the statewide-standardized amount,
8 the Department shall develop an adjustor to adjust the
9 rate of reimbursement for safety-net hospitals defined in
10 Section 5-5e.1 of this Code excluding pediatric hospitals.

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

18 (7.5) (Blank).

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

26 (9) Beginning July 1, 2018, in addition to the

1 statewide-standardized amount, the Department shall apply
2 the same adjustor that is applied to trauma cases as of
3 December 31, 2017 to inpatient claims to treat patients
4 with burns, including, but not limited to, APR-DRGs 841,
5 842, 843, and 844.

6 (10) Beginning July 1, 2018, the
7 statewide-standardized amount for inpatient general acute
8 care services shall be uniformly increased so that base
9 claims projected reimbursement is increased by an amount
10 equal to the funds allocated in paragraph (1) of
11 subsection (b) of Section 5A-12.6, less the amount
12 allocated under paragraphs (8) and (9) of this subsection
13 and paragraphs (3) and (4) of subsection (b) multiplied by
14 40%.

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

18 (b) Outpatient hospital services. Effective for dates of
19 service on and after July 1, 2014, reimbursement for
20 outpatient services shall utilize the Enhanced Ambulatory
21 Procedure Grouping (EAPG) software, version 3.7 distributed by
22 3MTM Health Information System.

23 (1) The Department shall establish Medicaid weighting
24 factors to be used in the reimbursement system established
25 under this subsection. The initial weighting factors shall
26 be the weighting factors as published by 3M Health

1 Information System, associated with Version 3.7.

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

5 (A) The initial statewide standardized amounts,
6 with the labor portion adjusted by the Calendar Year
7 2013 Medicare Outpatient Prospective Payment System
8 wage index with reclassifications, shall be published
9 by the Department on its website no later than 10
10 calendar days prior to their effective date.

11 (B) The Department shall establish adjustments to
12 the statewide-standardized amounts for each Critical
13 Access Hospital, as designated by the Department of
14 Public Health in accordance with 42 CFR 485, Subpart
15 F. For outpatient services provided on or before June
16 30, 2018, the EAPG standardized amounts are determined
17 separately for each critical access hospital such that
18 simulated EAPG payments using outpatient base period
19 paid claim data plus payments under Section 5A-12.4 of
20 this Code net of the associated tax costs are equal to
21 the estimated costs of outpatient base period claims
22 data with a rate year cost inflation factor applied.

23 (3) In addition to the statewide-standardized amounts,
24 the Department shall develop adjusters to adjust the rate
25 of reimbursement for critical Medicaid hospital outpatient
26 providers or services, including outpatient high volume or

1 safety-net hospitals. Beginning July 1, 2018, the
2 outpatient high volume adjustor shall be increased to
3 increase annual expenditures associated with this adjustor
4 by \$79,200,000, based on the State Fiscal Year 2015 base
5 year data and this adjustor shall apply to public
6 hospitals, except for large public hospitals, as defined
7 under 89 Ill. Adm. Code 148.25(a).

8 (4) Beginning July 1, 2018, in addition to the
9 statewide standardized amounts, the Department shall make
10 an add-on payment for outpatient expensive devices and
11 drugs. This add-on payment shall at least apply to claim
12 lines that: (i) are assigned with one of the following
13 EAPGs: 490, 1001 to 1020, and coded with one of the
14 following revenue codes: 0274 to 0276, 0278; or (ii) are
15 assigned with one of the following EAPGs: 430 to 441, 443,
16 444, 460 to 465, 495, 496, 1090. The add-on payment shall
17 be calculated as follows: the claim line's covered charges
18 multiplied by the hospital's total acute cost to charge
19 ratio, less the claim line's EAPG payment plus \$1,000,
20 multiplied by 0.8.

21 (5) Beginning July 1, 2018, the statewide-standardized
22 amounts for outpatient services shall be increased by a
23 uniform percentage so that base claims projected
24 reimbursement is increased by an amount equal to no less
25 than the funds allocated in paragraph (1) of subsection
26 (b) of Section 5A-12.6, less the amount allocated under

1 paragraphs (8) and (9) of subsection (a) and paragraphs
2 (3) and (4) of this subsection multiplied by 46%.

3 (6) Effective for dates of service on or after July 1,
4 2018, the Department shall establish adjustments to the
5 statewide-standardized amounts for each Critical Access
6 Hospital, as designated by the Department of Public Health
7 in accordance with 42 CFR 485, Subpart F, such that each
8 Critical Access Hospital's standardized amount for
9 outpatient services shall be increased by the applicable
10 uniform percentage determined pursuant to paragraph (5) of
11 this subsection. It is the intent of the General Assembly
12 that the adjustments required under this paragraph (6) by
13 Public Act 100-1181 shall be applied retroactively to
14 claims for dates of service provided on or after July 1,
15 2018.

16 (7) Effective for dates of service on or after March
17 8, 2019 (the effective date of Public Act 100-1181), the
18 Department shall recalculate and implement an updated
19 statewide-standardized amount for outpatient services
20 provided by hospitals that are not Critical Access
21 Hospitals to reflect the applicable uniform percentage
22 determined pursuant to paragraph (5).

23 (1) Any recalculation to the
24 statewide-standardized amounts for outpatient services
25 provided by hospitals that are not Critical Access
26 Hospitals shall be the amount necessary to achieve the

1 increase in the statewide-standardized amounts for
2 outpatient services increased by a uniform percentage,
3 so that base claims projected reimbursement is
4 increased by an amount equal to no less than the funds
5 allocated in paragraph (1) of subsection (b) of
6 Section 5A-12.6, less the amount allocated under
7 paragraphs (8) and (9) of subsection (a) and
8 paragraphs (3) and (4) of this subsection, for all
9 hospitals that are not Critical Access Hospitals,
10 multiplied by 46%.

11 (2) It is the intent of the General Assembly that
12 the recalculations required under this paragraph (7)
13 by Public Act 100-1181 shall be applied prospectively
14 to claims for dates of service provided on or after
15 March 8, 2019 (the effective date of Public Act
16 100-1181) and that no recoupment or repayment by the
17 Department or an MCO of payments attributable to
18 recalculation under this paragraph (7), issued to the
19 hospital for dates of service on or after July 1, 2018
20 and before March 8, 2019 (the effective date of Public
21 Act 100-1181), shall be permitted.

22 (8) The Department shall ensure that all necessary
23 adjustments to the managed care organization capitation
24 base rates necessitated by the adjustments under
25 subparagraph (6) or (7) of this subsection are completed
26 and applied retroactively in accordance with Section

1 5-30.8 of this Code within 90 days of March 8, 2019 (the
2 effective date of Public Act 100-1181).

3 (9) Within 60 days after federal approval of the
4 change made to the assessment in Section 5A-2 by this
5 amendatory Act of the 101st General Assembly, the
6 Department shall incorporate into the EAPG system for
7 outpatient services those services performed by hospitals
8 currently billed through the Non-Institutional Provider
9 billing system.

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

16 (c) In consultation with the hospital community, the
17 Department is authorized to replace 89 Ill. Admin. Code
18 152.150 as published in 38 Ill. Reg. 4980 through 4986 within
19 12 months of June 16, 2014 (the effective date of Public Act
20 98-651). If the Department does not replace these rules within
21 12 months of June 16, 2014 (the effective date of Public Act
22 98-651), the rules in effect for 152.150 as published in 38
23 Ill. Reg. 4980 through 4986 shall remain in effect until
24 modified by rule by the Department. Nothing in this subsection
25 shall be construed to mandate that the Department file a
26 replacement rule.

1 (d) Transition period. There shall be a transition period
2 to the reimbursement systems authorized under this Section
3 that shall begin on the effective date of these systems and
4 continue until June 30, 2018, unless extended by rule by the
5 Department. To help provide an orderly and predictable
6 transition to the new reimbursement systems and to preserve
7 and enhance access to the hospital services during this
8 transition, the Department shall allocate a transitional
9 hospital access pool of at least \$290,000,000 annually so that
10 transitional hospital access payments are made to hospitals.

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

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

25 (d-5) Hospital and health care transformation program. The
26 Department shall develop a hospital and health care

1 transformation program to provide financial assistance to
2 hospitals in transforming their services and care models to
3 better align with the needs of the communities they serve. The
4 payments authorized in this Section shall be subject to
5 approval by the federal government.

6 (1) Phase 1. In State fiscal years 2019 through 2020,
7 the Department shall allocate funds from the transitional
8 access hospital pool to create a hospital transformation
9 pool of at least \$262,906,870 annually and make hospital
10 transformation payments to hospitals. Subject to Section
11 5A-16, in State fiscal years 2019 and 2020, an Illinois
12 hospital that received either a transitional hospital
13 access payment under subsection (d) or a supplemental
14 payment under subsection (f) of this Section in State
15 fiscal year 2018, shall receive a hospital transformation
16 payment as follows:

17 (A) If the hospital's Rate Year 2017 Medicaid
18 inpatient utilization rate is equal to or greater than
19 45%, the hospital transformation payment shall be
20 equal to 100% of the sum of its transitional hospital
21 access payment authorized under subsection (d) and any
22 supplemental payment authorized under subsection (f).

23 (B) If the hospital's Rate Year 2017 Medicaid
24 inpatient utilization rate is equal to or greater than
25 25% but less than 45%, the hospital transformation
26 payment shall be equal to 75% of the sum of its

1 transitional hospital access payment authorized under
2 subsection (d) and any supplemental payment authorized
3 under subsection (f).

4 (C) If the hospital's Rate Year 2017 Medicaid
5 inpatient utilization rate is less than 25%, the
6 hospital transformation payment shall be equal to 50%
7 of the sum of its transitional hospital access payment
8 authorized under subsection (d) and any supplemental
9 payment authorized under subsection (f).

10 (2) Phase 2.

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

14 (B) Because there are communities in Illinois that
15 experience significant health care disparities due to
16 systemic racism, as recently emphasized by the
17 COVID-19 pandemic, aggravated by social determinants
18 of health and a lack of sufficiently allocated
19 healthcare resources, particularly community-based
20 services, preventive care, obstetric care, chronic
21 disease management, and specialty care, the Department
22 shall establish a health care transformation program
23 that shall be supported by the transformation funding
24 pool. It is the intention of the General Assembly that
25 innovative partnerships funded by the pool must be
26 designed to establish or improve integrated health

1 care delivery systems that will provide significant
2 access to the Medicaid and uninsured populations in
3 their communities, as well as improve health care
4 equity. It is also the intention of the General
5 Assembly that partnerships recognize and address the
6 disparities revealed by the COVID-19 pandemic, as well
7 as the need for post-COVID care. During State fiscal
8 years 2021 through 2027, the hospital and health care
9 transformation program shall be supported by an annual
10 transformation funding pool of up to \$150,000,000,
11 pending federal matching funds, to be allocated during
12 the specified fiscal years for the purpose of
13 facilitating hospital and health care transformation.
14 No disbursement of moneys for transformation projects
15 from the transformation funding pool described under
16 this Section shall be considered an award, a grant, or
17 an expenditure of grant funds. Funding agreements made
18 in accordance with the transformation program shall be
19 considered purchases of care under the Illinois
20 Procurement Code, and funds shall be expended by the
21 Department in a manner that maximizes federal funding
22 to expend the entire allocated amount.

23 The Department shall convene, within 30 days after
24 the effective date of this amendatory Act of the 101st
25 General Assembly, a workgroup that includes subject
26 matter experts on healthcare disparities and

1 stakeholders from distressed communities, which could
2 be a subcommittee of the Medicaid Advisory Committee,
3 to review and provide recommendations on how
4 Department policy, including health care
5 transformation, can improve health disparities and the
6 impact on communities disproportionately affected by
7 COVID-19. The workgroup shall consider and make
8 recommendations on the following issues: a community
9 safety-net designation of certain hospitals, racial
10 equity, and a regional partnership to bring additional
11 specialty services to communities.

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

22 (D) As provided in subsection (a-20) of Section
23 32.5 of the Emergency Medical Services (EMS) Systems
24 Act, a hospital that received hospital transformation
25 payments under this Section may convert to a
26 freestanding emergency center. To be eligible for such

1 a conversion, the hospital must submit to the
2 Department of Public Health approval from the
3 Department that the project is a part of the
4 hospital's transformation.

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

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

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

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

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

1 by the Department;

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

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

8 (F) Entities eligible to be funded.

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

16 (ii) The Department shall prioritize
17 partnerships from distressed communities, which
18 include Business Enterprise Program certified
19 vendors or other entities controlled and managed
20 by minorities or women and also include one or
21 more of the following: safety-net hospitals,
22 critical access hospitals, the campuses of
23 hospitals that have closed since January 1, 2018,
24 or other healthcare providers designed to address
25 specific healthcare disparities, including the
26 impact of COVID-19 on individuals and the

1 community and the need for post-COVID care. All
2 funded proposals must include specific measurable
3 goals and metrics related to improved outcomes and
4 reduced disparities which shall be tracked by the
5 Department.

6 (iii) The Department should target the funding
7 in the following ways: \$30,000,000 of
8 transformation funds to projects that are a
9 collaboration between a safety-net hospital,
10 particularly community safety-net hospitals, and
11 other providers and designed to address specific
12 healthcare disparities, \$20,000,000 of
13 transformation funds to collaborations between
14 safety-net hospitals and a larger hospital partner
15 that increases specialty care in distressed
16 communities, \$30,000,000 of transformation funds
17 to projects that are a collaboration between
18 hospitals and other providers in distressed areas
19 of the State designed to address specific
20 healthcare disparities, \$15,000,000 to
21 collaborations between critical access hospitals
22 and other providers designed to address specific
23 healthcare disparities, and \$15,000,000 to
24 cross-provider collaborations designed to address
25 specific healthcare disparities, and \$5,000,000 to
26 collaborations that focus on workforce

1 development.

2 (iv) The Department may allocate up to
3 \$5,000,000 for planning, racial equity analysis,
4 or consulting resources for the Department or
5 entities without the resources to develop a plan
6 to meet the criteria of this Section. Any contract
7 for consulting services issued by the Department
8 under this subparagraph shall comply with the
9 provisions of Section 5-45 of the State Officials
10 and Employees Ethics Act. Based on availability of
11 federal funding, the Department may directly
12 procure consulting services or provide funding to
13 the collaboration. The provision of resources
14 under this subparagraph is not a guarantee that a
15 project will be approved.

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

22 (G) Process for submitting and approving projects
23 for distressed communities. The Department shall issue
24 a template for application. The Department shall post
25 any proposal received on the Department's website for
26 at least 2 weeks for public comment, and any such

1 public comment shall also be considered in the review
2 process. Applicants may request that proprietary
3 financial information be redacted from publicly posted
4 proposals and the Department in its discretion may
5 agree. Proposals for each distressed community must
6 include all of the following:

7 (i) A detailed description of how the project
8 intends to affect the goals outlined in this
9 subsection, describing new interventions, new
10 technology, new structures, and other changes to
11 the healthcare delivery system planned.

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

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

1 proposal.

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

6 (v) A timeline showing the evolution of sites
7 and specific services of the project over a 5-year
8 period, including services available to the
9 community by site.

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

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

24 (viii) If the community study utilized is not
25 the study commissioned and published by the
26 Department, the applicant must define the

1 methodology used, including documentation of clear
2 community participation.

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

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

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

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

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

1 proposal.

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

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

9 (H) The Department shall evaluate proposals for
10 compliance with the criteria listed under subparagraph
11 (G). Proposals meeting all of the criteria may be
12 eligible for funding with the areas of focus
13 prioritized as described in item (ii) of subparagraph
14 (F). Based on the funds available, the Department may
15 negotiate funding agreements with approved applicants
16 to maximize federal funding. Nothing in this
17 subsection requires that an approved project be funded
18 to the level requested. Agreements shall specify the
19 amount of funding anticipated annually, the
20 methodology of payments, the limit on the number of
21 years such funding may be provided, and the milestones
22 and quality metrics that must be met by the projects in
23 order to continue to receive funding during each year
24 of the program. Agreements shall specify the terms and
25 conditions under which a health care facility that
26 receives funds under a purchase of care agreement and

1 closes in violation of the terms of the agreement must
2 pay an early closure fee no greater than 50% of the
3 funds it received under the agreement, prior to the
4 Health Facilities and Services Review Board
5 considering an application for closure of the
6 facility. Any project that is funded shall be required
7 to provide quarterly written progress reports, in a
8 form prescribed by the Department, and at a minimum
9 shall include the progress made in achieving any
10 milestones or metrics or Business Enterprise Program
11 commitments in its plan. The Department may reduce or
12 end payments, as set forth in transformation plans, if
13 milestones or metrics or Business Enterprise Program
14 commitments are not achieved. The Department shall
15 seek to make payments from the transformation fund in
16 a manner that is eligible for federal matching funds.

17 In reviewing the proposals, the Department shall
18 take into account the needs of the community, data
19 from the study commissioned by the Department from the
20 University of Illinois-Chicago if applicable, feedback
21 from public comment on the Department's website, as
22 well as how the proposal meets the criteria listed
23 under subparagraph (G). Alignment with the
24 Department's overall strategic initiatives shall be an
25 important factor. To the extent that fiscal year
26 funding is not adequate to fund all eligible projects

1 that apply, the Department shall prioritize
2 applications that most comprehensively and effectively
3 address the criteria listed under subparagraph (G).

4 (3) (Blank).

5 (4) Hospital Transformation Review Committee. There is
6 created the Hospital Transformation Review Committee. The
7 Committee shall consist of 14 members. No later than 30
8 days after March 12, 2018 (the effective date of Public
9 Act 100-581), the 4 legislative leaders shall each appoint
10 3 members; the Governor shall appoint the Director of
11 Healthcare and Family Services, or his or her designee, as
12 a member; and the Director of Healthcare and Family
13 Services shall appoint one member. Any vacancy shall be
14 filled by the applicable appointing authority within 15
15 calendar days. The members of the Committee shall select a
16 Chair and a Vice-Chair from among its members, provided
17 that the Chair and Vice-Chair cannot be appointed by the
18 same appointing authority and must be from different
19 political parties. The Chair shall have the authority to
20 establish a meeting schedule and convene meetings of the
21 Committee, and the Vice-Chair shall have the authority to
22 convene meetings in the absence of the Chair. The
23 Committee may establish its own rules with respect to
24 meeting schedule, notice of meetings, and the disclosure
25 of documents; however, the Committee shall not have the
26 power to subpoena individuals or documents and any rules

1 must be approved by 9 of the 14 members. The Committee
2 shall perform the functions described in this Section and
3 advise and consult with the Director in the administration
4 of this Section. In addition to reviewing and approving
5 the policies, procedures, and rules for the hospital and
6 health care transformation program, the Committee shall
7 consider and make recommendations related to qualifying
8 criteria and payment methodologies related to safety-net
9 hospitals and children's hospitals. Members of the
10 Committee appointed by the legislative leaders shall be
11 subject to the jurisdiction of the Legislative Ethics
12 Commission, not the Executive Ethics Commission, and all
13 requests under the Freedom of Information Act shall be
14 directed to the applicable Freedom of Information officer
15 for the General Assembly. The Department shall provide
16 operational support to the Committee as necessary. The
17 Committee is dissolved on April 1, 2019.

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

25 (f) Continuation of supplemental payments. Any
26 supplemental payments authorized under Illinois Administrative

1 Code 148 effective January 1, 2014 and that continue during
2 the period of July 1, 2014 through December 31, 2014 shall
3 remain in effect as long as the assessment imposed by Section
4 5A-2 that is in effect on December 31, 2017 remains in effect.

5 (g) Notwithstanding subsections (a) through (f) of this
6 Section and notwithstanding the changes authorized under
7 Section 5-5b.1, any updates to the system shall not result in
8 any diminishment of the overall effective rates of
9 reimbursement as of the implementation date of the new system
10 (July 1, 2014). These updates shall not preclude variations in
11 any individual component of the system or hospital rate
12 variations. Nothing in this Section shall prohibit the
13 Department from increasing the rates of reimbursement or
14 developing payments to ensure access to hospital services.
15 Nothing in this Section shall be construed to guarantee a
16 minimum amount of spending in the aggregate or per hospital as
17 spending may be impacted by factors, including, but not
18 limited to, the number of individuals in the medical
19 assistance program and the severity of illness of the
20 individuals.

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

26 (i) Except for subsections (g) and (h) of this Section,

1 the Department shall, pursuant to subsection (c) of Section
2 5-40 of the Illinois Administrative Procedure Act, provide for
3 presentation at the June 2014 hearing of the Joint Committee
4 on Administrative Rules (JCAR) additional written notice to
5 JCAR of the following rules in order to commence the second
6 notice period for the following rules: rules published in the
7 Illinois Register, rule dated February 21, 2014 at 38 Ill.
8 Reg. 4559 (Medical Payment), 4628 (Specialized Health Care
9 Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic
10 Related Grouping (DRG) Prospective Payment System (PPS)), and
11 4977 (Hospital Reimbursement Changes), and published in the
12 Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499
13 (Specialized Health Care Delivery Systems) and 6505 (Hospital
14 Services).

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

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

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

3 ARTICLE 10.

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

6 (305 ILCS 5/5-18.5)

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

9 (a) As used in this Section:

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

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

23 "Perinatal doula training" means any doula training that

1 focuses on providing support throughout the prenatal, labor
2 and delivery, or postpartum period, and reflects the type of
3 doula care that the doula seeks to provide.

4 (b) Notwithstanding any other provision of this Article,
5 perinatal doula services and evidence-based home visiting
6 services shall be covered under the medical assistance
7 program, subject to appropriation, for persons who are
8 otherwise eligible for medical assistance under this Article.
9 Perinatal doula services include regular visits beginning in
10 the prenatal period and continuing into the postnatal period,
11 inclusive of continuous support during labor and delivery,
12 that support healthy pregnancies and positive birth outcomes.
13 Perinatal doula services may be embedded in an existing
14 program, such as evidence-based home visiting. Perinatal doula
15 services provided during the prenatal period may be provided
16 weekly, services provided during the labor and delivery period
17 may be provided for the entire duration of labor and the time
18 immediately following birth, and services provided during the
19 postpartum period may be provided up to 12 months postpartum.

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

1 (c) The Department of Healthcare and Family Services shall
 2 adopt rules to administer this Section. In this rulemaking,
 3 the Department shall consider the expertise of and consult
 4 with doula program experts, doula training providers,
 5 practicing doulas, and home visiting experts, along with State
 6 agencies implementing perinatal doula services and relevant
 7 bodies under the Illinois Early Learning Council. This body of
 8 experts shall inform the Department on the credentials
 9 necessary for perinatal doula and home visiting services to be
 10 eligible for Medicaid reimbursement and the rate of
 11 reimbursement for home visiting and perinatal doula services
 12 in the prenatal, labor and delivery, and postpartum periods.
 13 Every 2 years, the Department shall assess the rates of
 14 reimbursement for perinatal doula and home visiting services
 15 and adjust rates accordingly.

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

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

21 ARTICLE 15.

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

1 (305 ILCS 5/5-4) (from Ch. 23, par. 5-4)

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

3 (a) The amount and nature of medical assistance shall be
4 determined in accordance with the standards, rules, and
5 regulations of the Department of Healthcare and Family
6 Services, with due regard to the requirements and conditions
7 in each case, including contributions available from legally
8 responsible relatives. However, the amount and nature of such
9 medical assistance shall not be affected by the payment of any
10 grant under the Senior Citizens and Persons with Disabilities
11 Property Tax Relief Act or any distributions or items of
12 income described under subparagraph (X) of paragraph (2) of
13 subsection (a) of Section 203 of the Illinois Income Tax Act.
14 The amount and nature of medical assistance shall not be
15 affected by the receipt of donations or benefits from
16 fundraisers in cases of serious illness, as long as neither
17 the person nor members of the person's family have actual
18 control over the donations or benefits or the disbursement of
19 the donations or benefits.

20 In determining the income and resources available to the
21 institutionalized spouse and to the community spouse, the
22 Department of Healthcare and Family Services shall follow the
23 procedures established by federal law. If an institutionalized
24 spouse or community spouse refuses to comply with the
25 requirements of Title XIX of the federal Social Security Act
26 and the regulations duly promulgated thereunder by failing to

1 provide the total value of assets, including income and
2 resources, to the extent either the institutionalized spouse
3 or community spouse has an ownership interest in them pursuant
4 to 42 U.S.C. 1396r-5, such refusal may result in the
5 institutionalized spouse being denied eligibility and
6 continuing to remain ineligible for the medical assistance
7 program based on failure to cooperate.

8 Subject to federal approval, beginning January 1, 2023,
9 the community spouse resource allowance shall be established
10 and maintained as follows: a base amount of \$109,560 plus an
11 additional amount of \$2,784 added to the base amount each year
12 for a period of 10 years commencing with calendar year 2024
13 through calendar year 2034. In addition to the base amount and
14 the additional amount shall be any increase each year from the
15 prior year to the maximum resource allowance permitted under
16 Section 1924(f)(2)(A)(ii)(II) of the Social Security Act.
17 Subject to federal approval, beginning January 1, 2034 the
18 community spouse resource allowance shall be established and
19 maintained at the maximum amount permitted under Section
20 1924(f)(2)(A)(ii)(II) of the Social Security Act, as now or
21 hereafter amended, or an amount set after a fair hearing.

22 Subject to federal approval, beginning January 1, 2023 the ~~the~~
23 ~~community spouse resource allowance shall be established and~~
24 ~~maintained at the higher of \$109,560 or the minimum level~~
25 ~~permitted pursuant to Section 1924(f)(2) of the Social~~
26 ~~Security Act, as now or hereafter amended, or an amount set~~

1 ~~after a fair hearing, whichever is greater.~~ The monthly
2 maintenance allowance for the community spouse shall be
3 established and maintained at the maximum amount ~~higher of~~
4 ~~\$2,739 per month or the minimum level~~ permitted pursuant to
5 Section 1924(d)(3) (C) of the Social Security Act, as now or
6 hereafter amended, or an amount set after a fair hearing,
7 whichever is greater. Subject to the approval of the Secretary
8 of the United States Department of Health and Human Services,
9 the provisions of this Section shall be extended to persons
10 who but for the provision of home or community-based services
11 under Section 4.02 of the Illinois Act on the Aging, would
12 require the level of care provided in an institution, as is
13 provided for in federal law.

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

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

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

1 support that may be ordered.

2 (iii) Proceedings may be initiated to obtain support,
3 or for the recovery of aid granted during the period such
4 support was not provided, or both, for the obtainment of
5 support and the recovery of the aid provided. Proceedings
6 for the recovery of aid may be taken separately or they may
7 be consolidated with actions to obtain support. Such
8 proceedings may be brought in the name of the person or
9 persons requiring support or may be brought in the name of
10 the Department, as the case requires.

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

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

24

ARTICLE 20.

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

4 (305 ILCS 5/5-5.05d new)

5 Sec. 5-5.05d. Academic detailing for behavioral health
6 providers. The Department shall develop, in collaboration with
7 associations representing behavioral health providers, a
8 program designed to provide behavioral health providers and
9 providers in academic medical settings who need assistance in
10 caring for patients with severe mental illness or a
11 developmental disability under the medical assistance program
12 with academic detailing and clinical consultation over the
13 phone from a qualified provider on how to best care for the
14 patient. The Department shall include the phone number on its
15 website and notify providers that the service is available.
16 The Department may create an in-person option if adequate
17 staff is available. To the extent practicable, the Department
18 shall build upon this service to address worker shortages and
19 the availability of specialty services.

20 (305 ILCS 5/5-5.05e new)

21 Sec. 5-5.05e. Tracking availability of beds for withdrawal
22 management services. The Department of Human Services shall
23 track, or contract with an organization to track, the
24 availability of beds for withdrawal management services that

1 are licensed by the Department and are available to medical
2 assistance beneficiaries. The Department of Human Services
3 shall update the tracking daily and publish the availability
4 of beds online or in another public format.

5 (305 ILCS 5/5-5.05f new)

6 Sec. 5-5.05f. Medicaid coverage for peer recovery support
7 services. On or before January 1, 2023, the Department shall
8 seek approval from the federal Centers for Medicare and
9 Medicaid Services to cover peer recovery support services
10 under the medical assistance program when rendered by
11 certified peer support specialists for the purposes of
12 supporting the recovery of individuals receiving substance use
13 disorder treatment. As used in this Section, "certified peer
14 support specialist" means an individual who:

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

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

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

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

8 (305 ILCS 5/5-5.05g new)

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

17 (305 ILCS 5/5-5.06c new)

18 Sec. 5-5.06c. Access to prenatal and postpartum care. To
19 ensure access to high quality prenatal and postpartum care and
20 to promote continuity of care for pregnant individuals, the
21 Department shall increase the rate for prenatal and postpartum
22 visits to no less than the rate for an adult well visit,
23 including any applicable add-ons, beginning on January 1,
24 2023. Bundled rates that include prenatal or postpartum visits

1 shall incorporate this increased rate, beginning on January 1,
2 2023.

3 (305 ILCS 5/5-5.06d new)

4 Sec. 5-5.06d. External cephalic version rate. To encourage
5 provider use of external cephalic versions and decrease the
6 rates of caesarean sections in Illinois, the Department shall
7 evaluate the rate for external cephalic versions and increase
8 the rate by an amount determined by the Department to promote
9 safer birthing options for pregnant individuals, beginning on
10 January 1, 2023.

11 ARTICLE 25.

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

14 (305 ILCS 5/5-5.06e new)

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

20 ARTICLE 30.

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

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

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

1 optometrist, whichever the person may select; (13) other
2 diagnostic, screening, preventive, and rehabilitative
3 services, including to ensure that the individual's need for
4 intervention or treatment of mental disorders or substance use
5 disorders or co-occurring mental health and substance use
6 disorders is determined using a uniform screening, assessment,
7 and evaluation process inclusive of criteria, for children and
8 adults; for purposes of this item (13), a uniform screening,
9 assessment, and evaluation process refers to a process that
10 includes an appropriate evaluation and, as warranted, a
11 referral; "uniform" does not mean the use of a singular
12 instrument, tool, or process that all must utilize; (14)
13 transportation and such other expenses as may be necessary;
14 (15) medical treatment of sexual assault survivors, as defined
15 in Section 1a of the Sexual Assault Survivors Emergency
16 Treatment Act, for injuries sustained as a result of the
17 sexual assault, including examinations and laboratory tests to
18 discover evidence which may be used in criminal proceedings
19 arising from the sexual assault; (16) the diagnosis and
20 treatment of sickle cell anemia; (16.5) services performed by
21 a chiropractic physician licensed under the Medical Practice
22 Act of 1987 and acting within the scope of his or her license,
23 including, but not limited to, chiropractic manipulative
24 treatment; and (17) any other medical care, and any other type
25 of remedial care recognized under the laws of this State. The
26 term "any other type of remedial care" shall include nursing

1 care and nursing home service for persons who rely on
2 treatment by spiritual means alone through prayer for healing.

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

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

15 Notwithstanding any other provision of this Section, all
16 tobacco cessation medications approved by the United States
17 Food and Drug Administration and all individual and group
18 tobacco cessation counseling services and telephone-based
19 counseling services and tobacco cessation medications provided
20 through the Illinois Tobacco Quitline shall be covered under
21 the medical assistance program for persons who are otherwise
22 eligible for assistance under this Article. The Department
23 shall comply with all federal requirements necessary to obtain
24 federal financial participation, as specified in 42 CFR
25 433.15(b)(7), for telephone-based counseling services provided
26 through the Illinois Tobacco Quitline, including, but not

1 limited to: (i) entering into a memorandum of understanding or
2 interagency agreement with the Department of Public Health, as
3 administrator of the Illinois Tobacco Quitline; and (ii)
4 developing a cost allocation plan for Medicaid-allowable
5 Illinois Tobacco Quitline services in accordance with 45 CFR
6 95.507. The Department shall submit the memorandum of
7 understanding or interagency agreement, the cost allocation
8 plan, and all other necessary documentation to the Centers for
9 Medicare and Medicaid Services for review and approval.
10 Coverage under this paragraph shall be contingent upon federal
11 approval.

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

19 Upon receipt of federal approval of an amendment to the
20 Illinois Title XIX State Plan for this purpose, the Department
21 shall authorize the Chicago Public Schools (CPS) to procure a
22 vendor or vendors to manufacture eyeglasses for individuals
23 enrolled in a school within the CPS system. CPS shall ensure
24 that its vendor or vendors are enrolled as providers in the
25 medical assistance program and in any capitated Medicaid
26 managed care entity (MCE) serving individuals enrolled in a

1 school within the CPS system. Under any contract procured
2 under this provision, the vendor or vendors must serve only
3 individuals enrolled in a school within the CPS system. Claims
4 for services provided by CPS's vendor or vendors to recipients
5 of benefits in the medical assistance program under this Code,
6 the Children's Health Insurance Program, or the Covering ALL
7 KIDS Health Insurance Program shall be submitted to the
8 Department or the MCE in which the individual is enrolled for
9 payment and shall be reimbursed at the Department's or the
10 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

22 On and after July 1, 2018, the Department of Healthcare
23 and Family Services shall provide dental services to any adult
24 who is otherwise eligible for assistance under the medical
25 assistance program. As used in this paragraph, "dental
26 services" means diagnostic, preventative, restorative, or

1 corrective procedures, including procedures and services for
2 the prevention and treatment of periodontal disease and dental
3 caries disease, provided by an individual who is licensed to
4 practice dentistry or dental surgery or who is under the
5 supervision of a dentist in the practice of his or her
6 profession.

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

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

1 Section are performed. The Department shall establish a
2 process for payment of claims for reimbursement for covered
3 dental services rendered under this provision.

4 On and after January 1, 2022, the Department of Healthcare
5 and Family Services shall administer and regulate a
6 school-based dental program that allows for the out-of-office
7 delivery of preventative dental services in a school setting
8 to children under 19 years of age. The Department shall
9 establish, by rule, guidelines for participation by providers
10 and set requirements for follow-up referral care based on the
11 requirements established in the Dental Office Reference Manual
12 published by the Department that establishes the requirements
13 for dentists participating in the All Kids Dental School
14 Program. Every effort shall be made by the Department when
15 developing the program requirements to consider the different
16 geographic differences of both urban and rural areas of the
17 State for initial treatment and necessary follow-up care. No
18 provider shall be charged a fee by any unit of local government
19 to participate in the school-based dental program administered
20 by the Department. Nothing in this paragraph shall be
21 construed to limit or preempt a home rule unit's or school
22 district's authority to establish, change, or administer a
23 school-based dental program in addition to, or independent of,
24 the school-based dental program administered by the
25 Department.

26 The Illinois Department, by rule, may distinguish and

1 classify the medical services to be provided only in
2 accordance with the classes of persons designated in Section
3 5-2.

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

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

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

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

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

26 (D) A comprehensive ultrasound screening and MRI of an

1 entire breast or breasts if a mammogram demonstrates
2 heterogeneous or dense breast tissue or when medically
3 necessary as determined by a physician licensed to
4 practice medicine in all of its branches.

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

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

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

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

24 For purposes of this Section:

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

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

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

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

17 If, at any time, the Secretary of the United States
18 Department of Health and Human Services, or its successor
19 agency, promulgates rules or regulations to be published in
20 the Federal Register or publishes a comment in the Federal
21 Register or issues an opinion, guidance, or other action that
22 would require the State, pursuant to any provision of the
23 Patient Protection and Affordable Care Act (Public Law
24 111-148), including, but not limited to, 42 U.S.C.
25 18031(d)(3)(B) or any successor provision, to defray the cost
26 of any coverage for breast tomosynthesis outlined in this

1 paragraph, then the requirement that an insurer cover breast
2 tomosynthesis is inoperative other than any such coverage
3 authorized under Section 1902 of the Social Security Act, 42
4 U.S.C. 1396a, and the State shall not assume any obligation
5 for the cost of coverage for breast tomosynthesis set forth in
6 this paragraph.

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

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

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

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

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

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

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

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

1 form of a quality performance bonus to primary care providers
2 who meet that goal.

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

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

25 On or after July 1, 2022, individuals who are otherwise
26 eligible for medical assistance under this Article shall

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

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

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

25 The Illinois Department, in cooperation with the
26 Departments of Human Services (as successor to the Department

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

7 Neither the Department of Healthcare and Family Services
8 nor the Department of Human Services shall sanction the
9 recipient solely on the basis of the recipient's substance
10 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 120
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 the 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 or hospital fees related to the dispensing, distribution,
24 and administration of the opioid antagonist, shall be covered
25 under the medical assistance program for persons who are
26 otherwise eligible for medical assistance under this Article.

1 As used in this Section, "opioid antagonist" means a drug that
2 binds to opioid receptors and blocks or inhibits the effect of
3 opioids acting on those receptors, including, but not limited
4 to, naloxone hydrochloride or any other similarly acting drug
5 approved by 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 Within 90 days after October 8, 2021 (the effective date

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

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

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

24 Notwithstanding any other provision of this Code, within
25 12 months after the effective date of this amendatory Act of
26 the 102nd General Assembly and subject to federal approval,

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

8 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;
9 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article
10 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section
11 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;
12 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.
13 1-1-22; 102-665, eff. 10-8-21; revised 11-18-21.)

14 ARTICLE 35.

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

18 (20 ILCS 2310/2310-434 new)

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

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

1 Housing Act.

2 (b) The Department shall establish or approve a Certified
3 Nursing Assistant Intern Program to address the increasing
4 need for trained health care workers and provide additional
5 pathways for individuals to become certified nursing
6 assistants. Upon successful completion of the classroom
7 education and on-the-job training requirements of the Program
8 required under this Section, an individual may provide, at a
9 facility, the patient and resident care services determined
10 under the Program and may perform the procedures listed under
11 subsection (e).

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

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

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

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

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

6 (1) The training program instructor shall be either an
7 advanced practice registered nurse or a registered nurse
8 who holds a bachelor's degree in nursing, has a minimum of
9 3 years of continuous experience in geriatric care, or is
10 certified as a nursing assistant instructor.

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

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

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

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

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

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

12 (3) Washing a resident's hands.

13 (4) Performing oral hygiene on a resident.

14 (5) Shaving a resident with an electric razor.

15 (6) Giving a resident a partial bath.

16 (7) Making a bed that is occupied.

17 (8) Dressing a resident.

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

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

22 (11) Feeding a resident.

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

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

25 (14) The Heimlich maneuver.

26 (f) A certified nursing assistant intern may not perform

1 any of the following on a resident:

2 (1) Shaving with a nonelectric razor.

3 (2) Nail care.

4 (3) Perineal care.

5 (4) Transfer using a mechanical lift.

6 (5) Passive range of motion.

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

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

18 (i) A Program participant who has completed the training
19 required under paragraph (5) of subsection (a) of Section
20 3-206 of the Nursing Home Care Act, has completed the Program
21 from April 21, 2020 through September 18, 2020, and has shown
22 competency in all of the performance skills listed under
23 subsection (e) may be considered a certified nursing assistant
24 intern once the observing advanced practice registered nurse
25 or registered nurse educator has confirmed the Program
26 participant's competency in all of those performance skills.

1 (j) The requirement under subsection (b) of Section
2 395.400 of Title 77 of the Illinois Administrative Code that a
3 student must pass a BNATP written competency examination
4 within 12 months after the completion of the BNATP does not
5 apply to a certified nursing assistant intern under this
6 Section. However, upon a Program participant's enrollment in a
7 certified nursing assistant course, the requirement under
8 subsection (b) of Section 395.400 of Title 77 of the Illinois
9 Administrative Code that a student pass a BNATP written
10 competency examination within 12 months after completion of
11 the BNATP program applies.

12 (k) A certified nursing assistant intern shall enroll in a
13 certified nursing assistant program within 6 months after
14 completing his or her certified nursing assistant intern
15 training under the Program. The individual may continue to
16 work as a certified nursing assistant intern during his or her
17 certified nursing assistant training. If the scope of work for
18 a nurse assistant in training pursuant to 77 Ill. Adm. Code
19 300.660 is broader in scope than the work permitted to be
20 performed by a certified nursing assistant intern, then the
21 certified nursing assistant intern enrolled in certified
22 nursing assistant training may perform the work allowed under
23 77. Ill. Adm. Code 300.660 with written documentation that the
24 certified nursing assistant intern has successfully passed the
25 competencies necessary to perform such skills. The facility
26 shall maintain documentation as to the additional jobs and

1 duties the certified nursing assistant intern is authorized to
2 perform, which shall be made available to the Department upon
3 request. The individual shall receive one hour of credit for
4 every hour employed as a certified nursing assistant intern or
5 as a temporary nurse assistant, not to exceed 30 hours of
6 credit, subject to the approval of an accredited certified
7 nursing assistant training program.

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

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

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

24 (3) not have been cited for a violation that resulted
25 in a pattern of certified nursing assistants being removed
26 from the Health Care Worker Registry as a result of

1 resident abuse, neglect, or exploitation within the 2
2 years prior to employing a certified nursing assistant
3 intern;

4 (4) if the facility is a skilled nursing facility,
5 meet a minimum staffing ratio of 3.8 hours of nursing and
6 personal care time, as those terms are used in subsection
7 (e) of Section 3-202.05 of the Nursing Home Care Act, each
8 day for a resident needing skilled care and 2.5 hours of
9 nursing and personal care time each day for a resident
10 needing intermediate care;

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

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

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

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

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

1 or licensure requirements.

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

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

26 (o) The Department may adopt emergency rules in accordance

1 with Section 5-45.21 of the Illinois Administrative Procedure
2 Act.

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

7 (q) This Section is inoperative 18 months after the
8 Program end date determined under subsection (p).

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

11 (210 ILCS 9/77 new)

12 Sec. 77. Certified nursing assistant interns.

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

18 (b) An establishment shall notify its certified and
19 licensed staff members, in writing, that a certified nursing
20 assistant intern may only provide the services and perform the
21 procedures permitted under Section 2310-434 of the Department
22 of Public Health Powers and Duties Law of the Civil
23 Administrative Code of Illinois. The notification shall detail
24 which duties may be delegated to a certified nursing assistant

1 intern. The establishment shall establish a policy describing
2 the authorized duties, supervision, and evaluation of
3 certified nursing assistant interns available upon request of
4 the Department and any surveyor.

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

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

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

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

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

17 (d) An establishment that employs a certified nursing
18 assistant intern in violation of this Section shall be subject
19 to civil penalties or fines under subsection (a) of Section
20 135.

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

23 (210 ILCS 45/3-613 new)

24 Sec. 3-613. Certified nursing assistant interns.

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

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

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

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

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

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

26 (4) ensure that a thorough assessment of any resident

1 involved in the work performed is completed by a
2 registered nurse.

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

6 (e) A minimum of 50% of nursing and personal care time
7 shall be provided by a certified nursing assistant, but no
8 more than 15% of nursing and personal care time may be provided
9 by a certified nursing assistant intern.

10 Section 35-20. The MC/DD Act is amended by adding Section
11 3-613 as follows:

12 (210 ILCS 46/3-613 new)

13 Sec. 3-613. Certified nursing assistant interns.

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

19 (b) A facility shall notify its certified and licensed
20 staff members, in writing, that a certified nursing assistant
21 intern may only provide the services and perform the
22 procedures permitted under Section 2310-434 of the Department
23 of Public Health Powers and Duties Law of the Civil
24 Administrative Code of Illinois. The notification shall detail

1 which duties may be delegated to a certified nursing assistant
2 intern. The facility shall establish a policy describing the
3 authorized duties, supervision, and evaluation of certified
4 nursing assistant interns available upon request of the
5 Department and any surveyor.

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

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

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

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

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

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

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

23 (210 ILCS 47/3-613 new)

24 Sec. 3-613. Certified nursing assistant interns.

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

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

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

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

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

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

26 (4) ensure that a thorough assessment of any resident

1 involved in the work performed is completed by a
2 registered nurse.

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

6 Section 35-30. The Illinois Public Aid Code is amended by
7 adding Section 5-5.01b as follows:

8 (305 ILCS 5/5-5.01b new)

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

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

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

24 (1) taken within the facility where the certified

1 nursing assistant intern will be employed;

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

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

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

15 (1) The training program instructor shall be either an
16 advanced practice registered nurse or a registered nurse
17 who holds a bachelor's degree in nursing, has a minimum of
18 3 years of continuous experience in geriatric care, or is
19 certified as a nursing assistant instructor.

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

26 (3) All on-the-job training shall be under the direct

1 observation of either an advanced practice registered
2 nurse or a registered nurse who holds a bachelor's degree
3 in nursing, has a minimum of 3 years of continuous
4 experience in geriatric care, or is certified as a nursing
5 assistant instructor.

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

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

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

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

21 (3) Washing a resident's hands.

22 (4) Performing oral hygiene on a resident.

23 (5) Shaving a resident with an electric razor.

24 (6) Giving a resident a partial bath.

25 (7) Making a bed that is occupied.

26 (8) Dressing a resident.

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

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

5 (11) Feeding a resident.

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

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

8 (14) The Heimlich maneuver.

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

11 (1) Shaving with a nonelectric razor.

12 (2) Nail care.

13 (3) Perineal care.

14 (4) Transfer using a mechanical lift.

15 (5) Passive range of motion.

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

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

26 (h) A facility shall notify its certified and licensed

1 staff members, in writing, that a certified nursing assistant
2 intern may only provide the services and perform the
3 procedures listed under subsection (d). The notification shall
4 detail which duties may be delegated to a certified nursing
5 assistant intern.

6 (i) If a facility learns that a certified nursing
7 assistant intern is performing work outside of the scope of
8 the Program's training, the facility shall:

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

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

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

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

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

22 (k) A Program participant who has completed the training
23 required under paragraph (5) of subsection (a) of Section
24 3-206 of the Nursing Home Care Act, has completed the Program
25 from April 21, 2020 through September 18, 2020, and has shown
26 competency in all of the performance skills listed under

1 subsection (d) shall be considered a certified nursing
2 assistant intern.

3 (l) The requirement under subsection (b) of Section
4 395.400 of Title 77 of the Illinois Administrative Code that a
5 student must pass a BNATP written competency examination
6 within 12 months after the completion of the BNATP does not
7 apply to a certified nursing assistant intern under this
8 Section. However, upon a Program participant's enrollment in a
9 certified nursing assistant course, the requirement under
10 subsection (b) of Section 395.400 of Title 77 of the Illinois
11 Administrative Code that a student pass a BNATP written
12 competency examination within 12 months after completion of
13 the BNATP program applies.

14 (m) A certified nursing assistant intern shall enroll in a
15 certified nursing assistant program within 6 months after
16 completing his or her certified nursing assistant intern
17 training under the Program. The individual may continue to
18 work as a certified nursing assistant intern during his or her
19 certified nursing assistant training. If the scope of work for
20 a nurse assistant in training pursuant to 77 Ill. Adm. Code
21 300.660 is broader in scope than the work permitted to be
22 performed by a certified nursing assistant intern, then the
23 certified nursing assistant intern enrolled in certified
24 nursing assistant training may perform the work allowed under
25 77. Ill. Adm. Code 300.660. The individual shall receive one
26 hour of credit for every hour employed as a certified nursing

1 assistant intern or as a temporary nurse assistant, not to
2 exceed 30 hours of credit, subject to the approval of an
3 accredited certified nursing assistant training program.

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

6 (1) not have received a substantiated citation, that
7 the facility has the right to the appeal, for a violation
8 that has caused severe harm to or the death of a resident
9 within the 2 years prior to employing a certified nursing
10 assistant intern; and

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

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

24 (p) To study the effectiveness of the Program, the
25 Department shall collect data from participating facilities
26 and publish a report on the extent to which the Program brought

1 individuals into continuing employment as certified nursing
2 assistants in long-term care. Data collected from facilities
3 shall include, but shall not be limited to, the number of
4 certified nursing assistants employed, the number of persons
5 who began participation in the Program, the number of persons
6 who successfully completed the Program, and the number of
7 persons who continue employment in a long-term care service or
8 facility. The report shall be published no later than 6 months
9 after the Program end date determined under subsection (r). A
10 facility participating in the Program shall, twice annually,
11 submit data under this subsection in a manner and time
12 determined by the Department. Failure to submit data under
13 this subsection shall result in suspension of the facility's
14 Program.

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

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

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

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

1 (5 ILCS 100/5-45.21 new)

2 Sec. 5-45.21. Emergency rulemaking; Certified Nursing
3 Assistant Intern Program; Department of Public Health. To
4 provide for the expeditious and timely implementation of this
5 amendatory Act of the 102nd General Assembly, emergency rules
6 implementing Section 2310-434 of the Department of Public
7 Health Powers and Duties Law of the Civil Administrative Code
8 of Illinois may be adopted in accordance with Section 5-45 by
9 the Department of Public Health. The adoption of emergency
10 rules authorized by Section 5-45 and this Section is deemed to
11 be necessary for the public interest, safety, and welfare.

12 This Section is repealed one year after the effective date
13 of this amendatory Act of the 102nd General Assembly.

14 (5 ILCS 100/5-45.22 new)

15 Sec. 5-45.22. Emergency rulemaking; Certified Nursing
16 Assistant Intern Program; Department of Healthcare and Family
17 Services. To provide for the expeditious and timely
18 implementation of this amendatory Act of the 102nd General
19 Assembly, emergency rules implementing Section 5-5.01b of the
20 Illinois Public Aid Code may be adopted in accordance with
21 Section 5-45 by the Department of Healthcare and Family
22 Services. The adoption of emergency rules authorized by
23 Section 5-45 and this Section is deemed to be necessary for the
24 public interest, safety, and welfare.

1 This Section is repealed one year after the effective date
2 of this amendatory Act of the 102nd General Assembly.

3 ARTICLE 40.

4 Section 40-5. The Illinois Public Aid Code is amended by
5 changing Section 11-5.1 and by adding Sections 5-1.6, 5-13.1
6 and 11-5.5 as follows:

7 (305 ILCS 5/5-1.6 new)

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

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

20 (b) By July 1, 2022, the Department of Healthcare and
21 Family Services shall seek a State Plan amendment or any
22 federal waivers or approvals necessary to make changes to the
23 medical assistance redetermination process for people without

1 any income at the time of redetermination. These changes shall
2 seek to allow all people without income to be considered for ex
3 parte redetermination. If there is no non-income related
4 disqualifying information for medical assistance recipients
5 without any income, then a person without any income shall be
6 redetermined ex parte. Within 60 days after receiving federal
7 approval or guidance, the Department of Healthcare and Family
8 Services and the Department of Human Services shall make
9 necessary technical and rule changes to implement changes to
10 the redetermination process. The percentage of medical
11 assistance recipients whose eligibility is renewed through the
12 ex parte redetermination process shall be reported monthly by
13 the Department of Healthcare and Family Services on its
14 website in accordance with subsection (d) of Section 11-5.1 of
15 this Code as well as shared in all Medicaid Advisory Committee
16 meetings and Medicaid Advisory Committee Public Education
17 Subcommittee meetings.

18 (305 ILCS 5/5-13.1 new)

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

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

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

6 (1) Cost-effectiveness waiver. Subject to federal
7 approval, the Department shall waive any claim against the
8 first \$25,000 of any estate to prevent substantial and
9 unreasonable hardship. The Department shall consider the
10 gross assets in the estate, including, but not limited to,
11 the net value of real estate less mortgages or liens with
12 priority over the Department's claims. The Department may
13 increase the cost-effectiveness threshold in the future.

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

19 (3) Accessible information. The Department shall make
20 information about estate recovery and hardship waivers
21 easily accessible. The Department shall maintain
22 information about how to request a hardship waiver on its
23 website in English, Spanish, and the next 4 most commonly
24 used languages, including a short guide and simple form to
25 facilitate requesting hardship exemptions in each
26 language. On an annual basis, the Department shall

1 publicly report on the number of estate recovery cases
2 that are pursued and the number of undue hardship
3 exemptions granted, including demographic data of the
4 deceased beneficiaries where available.

5 (305 ILCS 5/11-5.1)

6 Sec. 11-5.1. Eligibility verification. Notwithstanding any
7 other provision of this Code, with respect to applications for
8 medical assistance provided under Article V of this Code,
9 eligibility shall be determined in a manner that ensures
10 program integrity and complies with federal laws and
11 regulations while minimizing unnecessary barriers to
12 enrollment. To this end, as soon as practicable, and unless
13 the Department receives written denial from the federal
14 government, this Section shall be implemented:

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

17 (1) By no later than July 1, 2011, require
18 verification of, at a minimum, one month's income from all
19 sources required for determining the eligibility of
20 applicants for medical assistance under this Code. Such
21 verification shall take the form of pay stubs, business or
22 income and expense records for self-employed persons,
23 letters from employers, and any other valid documentation
24 of income including data obtained electronically by the
25 Department or its designees from other sources as

1 described in subsection (b) of this Section. A month's
2 income may be verified by a single pay stub with the
3 monthly income extrapolated from the time period covered
4 by the pay stub.

5 (2) By no later than October 1, 2011, require
6 verification of, at a minimum, one month's income from all
7 sources required for determining the continued eligibility
8 of recipients at their annual review of eligibility for
9 medical assistance under this Code. Information the
10 Department receives prior to the annual review, including
11 information available to the Department as a result of the
12 recipient's application for other non-Medicaid benefits,
13 that is sufficient to make a determination of continued
14 Medicaid eligibility may be reviewed and verified, and
15 subsequent action taken including client notification of
16 continued Medicaid eligibility. The date of client
17 notification establishes the date for subsequent annual
18 Medicaid eligibility reviews. Such verification shall take
19 the form of pay stubs, business or income and expense
20 records for self-employed persons, letters from employers,
21 and any other valid documentation of income including data
22 obtained electronically by the Department or its designees
23 from other sources as described in subsection (b) of this
24 Section. A month's income may be verified by a single pay
25 stub with the monthly income extrapolated from the time
26 period covered by the pay stub. The Department shall send

1 a notice to recipients at least 60 days prior to the end of
2 their period of eligibility that informs them of the
3 requirements for continued eligibility. If a recipient
4 does not fulfill the requirements for continued
5 eligibility by the deadline established in the notice a
6 notice of cancellation shall be issued to the recipient
7 and coverage shall end no later than the last day of the
8 month following the last day of the eligibility period. A
9 recipient's eligibility may be reinstated without
10 requiring a new application if the recipient fulfills the
11 requirements for continued eligibility prior to the end of
12 the third month following the last date of coverage (or
13 longer period if required by federal regulations). Nothing
14 in this Section shall prevent an individual whose coverage
15 has been cancelled from reapplying for health benefits at
16 any time.

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

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

22 (b) The Department shall establish or continue cooperative
23 arrangements with the Social Security Administration, the
24 Illinois Secretary of State, the Department of Human Services,
25 the Department of Revenue, the Department of Employment
26 Security, and any other appropriate entity to gain electronic

1 access, to the extent allowed by law, to information available
2 to those entities that may be appropriate for electronically
3 verifying any factor of eligibility for benefits under the
4 Program. Data relevant to eligibility shall be provided for no
5 other purpose than to verify the eligibility of new applicants
6 or current recipients of health benefits under the Program.
7 Data shall be requested or provided for any new applicant or
8 current recipient only insofar as that individual's
9 circumstances are relevant to that individual's or another
10 individual's eligibility.

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

16 (d) As soon as practical if the data is reasonably
17 available, but no later than January 1, 2017, the Department
18 shall compile on a monthly basis data on eligibility
19 redeterminations of beneficiaries of medical assistance
20 provided under Article V of this Code. In addition to the other
21 data required under this subsection, the Department shall
22 compile on a monthly basis data on the percentage of
23 beneficiaries whose eligibility is renewed through ex parte
24 redeterminations as described in subsection (b) of Section
25 5-1.6 of this Code, subject to federal approval of the changes
26 made in subsection (b) of Section 5-1.6 by this amendatory Act

1 of the 102nd General Assembly. This data shall be posted on the
2 Department's website, and data from prior months shall be
3 retained and available on the Department's website. The data
4 compiled and reported shall include the following:

5 (1) The total number of redetermination decisions made
6 in a month and, of that total number, the number of
7 decisions to continue or change benefits and the number of
8 decisions to cancel benefits.

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

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

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

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

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

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

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

5 (F) The beneficiary's lack of response to a
6 request for additional information when reliable
7 information in the beneficiary's account, or other
8 more current information, is unavailable to the
9 Department to make a decision on whether to continue
10 benefits.

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

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

21 (5) Of the total number of benefit cancellations in a
22 month, the number of beneficiaries who return from
23 cancellation within one month, the number of beneficiaries
24 who return from cancellation within 2 months, and the
25 number of beneficiaries who return from cancellation
26 within 3 months. Of the number of beneficiaries who return

1 from cancellation within 3 months, the percentage of those
2 cancellations due to each of the reasons listed under
3 paragraph (3) of this subsection.

4 (e) The Department shall conduct a complete review of the
5 Medicaid redetermination process in order to identify changes
6 that can increase the use of ex parte redetermination
7 processing. This review shall be completed within 90 days
8 after the effective date of this amendatory Act of the 101st
9 General Assembly. Within 90 days of completion of the review,
10 the Department shall seek written federal approval of policy
11 changes the review recommended and implement once approved.
12 The review shall specifically include, but not be limited to,
13 use of ex parte redeterminations of the following populations:

14 (1) Recipients of developmental disabilities services.

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

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

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

21 (5) Populations with no verifiable income.

22 (6) Self-employed people.

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

26 (f) The Department shall explore and implement, as

1 practical and technologically possible, roles that
2 stakeholders outside State agencies can play to assist in
3 expediting eligibility determinations and redeterminations
4 within 24 months after the effective date of this amendatory
5 Act of the 101st General Assembly. Such practical roles to be
6 explored to expedite the eligibility determination processes
7 shall include the implementation of hospital presumptive
8 eligibility, as authorized by the Patient Protection and
9 Affordable Care Act.

10 (g) The Department or its designee shall seek federal
11 approval to enhance the reasonable compatibility standard from
12 5% to 10%.

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

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

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

24 (B) Medical redeterminations completed, including:

25 (i) a breakdown of the number of households that were
26 redetermined ex parte and those that were not; (ii)

1 the reasons households were not redetermined ex parte;
2 and (iii) the relative percentages of these reasons.

3 (C) A narrative discussion on issues identified in
4 the functioning of the State's Integrated Eligibility
5 System and progress on addressing those issues, as
6 well as progress on implementing strategies to address
7 eligibility backlogs, including expanding ex parte
8 determinations to ensure timely eligibility
9 determinations and renewals.

10 (2) Initial reports shall be issued within 90 days
11 after the effective date of this amendatory Act of the
12 101st General Assembly.

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

15 (i) It is the determination of the General Assembly that
16 the Department must include seniors and persons with
17 disabilities in ex parte renewals. It is the determination of
18 the General Assembly that the Department must use its asset
19 verification system to assist in the determination of whether
20 an individual's coverage can be renewed using the ex parte
21 process. If a State Plan amendment is required, the Department
22 shall pursue such State Plan amendment by July 1, 2022. Within
23 60 days after receiving federal approval or guidance, the
24 Department of Healthcare and Family Services and the
25 Department of Human Services shall make necessary technical
26 and rule changes to implement these changes to the

1 redetermination process.

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

3 (305 ILCS 5/11-5.5 new)

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

6 (a) The Department shall investigate how to align the
7 Medicare Part D Low-Income Subsidy and Medicare Savings
8 Program eligibility criteria.

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

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

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

19 (305 ILCS 5/3-10 rep.)

20 (305 ILCS 5/3-10.1 rep.)

21 (305 ILCS 5/3-10.2 rep.)

22 (305 ILCS 5/3-10.3 rep.)

23 (305 ILCS 5/3-10.4 rep.)

24 (305 ILCS 5/3-10.5 rep.)

1 (305 ILCS 5/3-10.6 rep.)
2 (305 ILCS 5/3-10.7 rep.)
3 (305 ILCS 5/3-10.8 rep.)
4 (305 ILCS 5/3-10.9 rep.)
5 (305 ILCS 5/3-10.10 rep.)
6 (305 ILCS 5/5-13.5 rep.)

7 Section 40-10. The Illinois Public Aid Code is amended by
8 repealing Sections 3-10, 3-10.1, 3-10.2, 3-10.3, 3-10.4,
9 3-10.5, 3-10.6, 3-10.7, 3-10.8, 3-10.9, and 3-10.10, and
10 5-13.5.

11 ARTICLE 45.

12 Section 45-5. The Illinois Public Aid Code is amended by
13 changing Section 5-5.07 as follows:

14 (305 ILCS 5/5-5.07)

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

1 discharge is being delayed due to a pending inquiry or
2 investigation by the Department of Children and Family
3 Services. If any portion of a hospital stay is reimbursed
4 under this Section, the hospital stay shall not be eligible
5 for payment under the provisions of Section 14-13 of this
6 Code. ~~This Section is inoperative on and after July 1, 2021.~~
7 ~~Notwithstanding the provision of Public Act 101-209 stating~~
8 ~~that this Section is inoperative on and after July 1, 2020,~~
9 ~~this Section is operative from July 1, 2020 through July 1,~~
10 ~~2023.~~

11 (Source: Reenacted by P.A. 101-15, eff. 6-14-19; reenacted by
12 P.A. 101-209, eff. 8-5-19; P.A. 101-655, eff. 3-12-21;
13 102-201, eff. 7-30-21; 102-558, eff. 8-20-21.)

14 ARTICLE 50.

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

17 (305 ILCS 5/5-4.2)

18 Sec. 5-4.2. Ambulance services payments.

19 (a) For ambulance services provided to a recipient of aid
20 under this Article on or after January 1, 1993, the Illinois
21 Department shall reimburse ambulance service providers at
22 rates calculated in accordance with this Section. It is the
23 intent of the General Assembly to provide adequate

1 reimbursement for ambulance services so as to ensure adequate
2 access to services for recipients of aid under this Article
3 and to provide appropriate incentives to ambulance service
4 providers to provide services in an efficient and
5 cost-effective manner. Thus, it is the intent of the General
6 Assembly that the Illinois Department implement a
7 reimbursement system for ambulance services that, to the
8 extent practicable and subject to the availability of funds
9 appropriated by the General Assembly for this purpose, is
10 consistent with the payment principles of Medicare. To ensure
11 uniformity between the payment principles of Medicare and
12 Medicaid, the Illinois Department shall follow, to the extent
13 necessary and practicable and subject to the availability of
14 funds appropriated by the General Assembly for this purpose,
15 the statutes, laws, regulations, policies, procedures,
16 principles, definitions, guidelines, and manuals used to
17 determine the amounts paid to ambulance service providers
18 under Title XVIII of the Social Security Act (Medicare).

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

26 (c) For purposes of this Section, "ambulance services"

1 includes medical transportation services provided by means of
2 an ambulance, medi-car, service car, or taxi.

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

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

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

25 (c-4) For purposes of this Section, "service car" means
26 transportation services provided to a patient by a passenger

1 vehicle where that patient does not require the specialized
2 modes described in subsection (c-1) or (c-3).

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

6 (e) Beginning with services rendered on or after July 1,
7 2008, all providers of non-emergency medi-car and service car
8 transportation must certify that the driver and employee
9 attendant, as applicable, have completed a safety program
10 approved by the Department to protect both the patient and the
11 driver, prior to transporting a patient. The provider must
12 maintain this certification in its records. The provider shall
13 produce such documentation upon demand by the Department or
14 its representative. Failure to produce documentation of such
15 training shall result in recovery of any payments made by the
16 Department for services rendered by a non-certified driver or
17 employee attendant. Medi-car and service car providers must
18 maintain legible documentation in their records of the driver
19 and, as applicable, employee attendant that actually
20 transported the patient. Providers must recertify all drivers
21 and employee attendants every 3 years. If they meet the
22 established training components set forth by the Department,
23 providers of non-emergency medi-car and service car
24 transportation that are either directly or through an
25 affiliated company licensed by the Department of Public Health
26 shall be approved by the Department to have in-house safety

1 programs for training their own staff.

2 Notwithstanding the requirements above, any public
3 transportation provider of medi-car and service car
4 transportation that receives federal funding under 49 U.S.C.
5 5307 and 5311 need not certify its drivers and employee
6 attendants under this Section, since safety training is
7 already federally mandated.

8 (f) With respect to any policy or program administered by
9 the Department or its agent regarding approval of
10 non-emergency medical transportation by ground ambulance
11 service providers, including, but not limited to, the
12 Non-Emergency Transportation Services Prior Approval Program
13 (NETSPAP), the Department shall establish by rule a process by
14 which ground ambulance service providers of non-emergency
15 medical transportation may appeal any decision by the
16 Department or its agent for which no denial was received prior
17 to the time of transport that either (i) denies a request for
18 approval for payment of non-emergency transportation by means
19 of ground ambulance service or (ii) grants a request for
20 approval of non-emergency transportation by means of ground
21 ambulance service at a level of service that entitles the
22 ground ambulance service provider to a lower level of
23 compensation from the Department than the ground ambulance
24 service provider would have received as compensation for the
25 level of service requested. The rule shall be filed by
26 December 15, 2012 and shall provide that, for any decision

1 rendered by the Department or its agent on or after the date
2 the rule takes effect, the ground ambulance service provider
3 shall have 60 days from the date the decision is received to
4 file an appeal. The rule established by the Department shall
5 be, insofar as is practical, consistent with the Illinois
6 Administrative Procedure Act. The Director's decision on an
7 appeal under this Section shall be a final administrative
8 decision subject to review under the Administrative Review
9 Law.

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

24 (f-6) Within 90 days after the effective date of this
25 amendatory Act of the 102nd General Assembly and subject to
26 federal approval, the Department shall file rules to allow for

1 the approval of ground ambulance services when the sole
2 purpose of the transport is for the navigation of stairs or the
3 assisting or lifting of a patient at a medical facility or
4 during a medical appointment in instances where the Department
5 or a contracted Medicaid managed care organization or their
6 transportation broker is unable to secure transportation
7 through any other transportation provider.

8 (f-7) For non-emergency ground ambulance claims properly
9 denied under Department policy at the time the claim is filed
10 due to failure to submit a valid Medical Certification for
11 Non-Emergency Ambulance on and after December 15, 2012 and
12 prior to January 1, 2021, the Department shall allot
13 \$2,000,000 to a pool to reimburse such claims if the provider
14 proves medical necessity for the service by other means.
15 Providers must submit any such denied claims for which they
16 seek compensation to the Department no later than December 31,
17 2021 along with documentation of medical necessity. No later
18 than May 31, 2022, the Department shall determine for which
19 claims medical necessity was established. Such claims for
20 which medical necessity was established shall be paid at the
21 rate in effect at the time of the service, provided the
22 \$2,000,000 is sufficient to pay at those rates. If the pool is
23 not sufficient, claims shall be paid at a uniform percentage
24 of the applicable rate such that the pool of \$2,000,000 is
25 exhausted. The appeal process described in subsection (f)
26 shall not be applicable to the Department's determinations

1 made in accordance with this subsection.

2 (g) Whenever a patient covered by a medical assistance
3 program under this Code or by another medical program
4 administered by the Department, including a patient covered
5 under the State's Medicaid managed care program, is being
6 transported from a facility and requires non-emergency
7 transportation including ground ambulance, medi-car, or
8 service car transportation, a Physician Certification
9 Statement as described in this Section shall be required for
10 each patient. Facilities shall develop procedures for a
11 licensed medical professional to provide a written and signed
12 Physician Certification Statement. The Physician Certification
13 Statement shall specify the level of transportation services
14 needed and complete a medical certification establishing the
15 criteria for approval of non-emergency ambulance
16 transportation, as published by the Department of Healthcare
17 and Family Services, that is met by the patient. This
18 certification shall be completed prior to ordering the
19 transportation service and prior to patient discharge. The
20 Physician Certification Statement is not required prior to
21 transport if a delay in transport can be expected to
22 negatively affect the patient outcome. If the ground ambulance
23 provider, medi-car provider, or service car provider is unable
24 to obtain the required Physician Certification Statement
25 within 10 calendar days following the date of the service, the
26 ground ambulance provider, medi-car provider, or service car

1 provider must document its attempt to obtain the requested
2 certification and may then submit the claim for payment.
3 Acceptable documentation includes a signed return receipt from
4 the U.S. Postal Service, facsimile receipt, email receipt, or
5 other similar service that evidences that the ground ambulance
6 provider, medi-car provider, or service car provider attempted
7 to obtain the required Physician Certification Statement.

8 The medical certification specifying the level and type of
9 non-emergency transportation needed shall be in the form of
10 the Physician Certification Statement on a standardized form
11 prescribed by the Department of Healthcare and Family
12 Services. Within 75 days after July 27, 2018 (the effective
13 date of Public Act 100-646), the Department of Healthcare and
14 Family Services shall develop a standardized form of the
15 Physician Certification Statement specifying the level and
16 type of transportation services needed in consultation with
17 the Department of Public Health, Medicaid managed care
18 organizations, a statewide association representing ambulance
19 providers, a statewide association representing hospitals, 3
20 statewide associations representing nursing homes, and other
21 stakeholders. The Physician Certification Statement shall
22 include, but is not limited to, the criteria necessary to
23 demonstrate medical necessity for the level of transport
24 needed as required by (i) the Department of Healthcare and
25 Family Services and (ii) the federal Centers for Medicare and
26 Medicaid Services as outlined in the Centers for Medicare and

1 Medicaid Services' Medicare Benefit Policy Manual, Pub.
2 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician
3 Certification Statement shall satisfy the obligations of
4 hospitals under Section 6.22 of the Hospital Licensing Act and
5 nursing homes under Section 2-217 of the Nursing Home Care
6 Act. Implementation and acceptance of the Physician
7 Certification Statement shall take place no later than 90 days
8 after the issuance of the Physician Certification Statement by
9 the Department of Healthcare and Family Services.

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

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

26 (h) On and after July 1, 2012, the Department shall reduce

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

5 (i) On and after July 1, 2018, the Department shall
6 increase the base rate of reimbursement for both base charges
7 and mileage charges for ground ambulance service providers for
8 medical transportation services provided by means of a ground
9 ambulance to a level not lower than 112% of the base rate in
10 effect as of June 30, 2018.

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

13 (305 ILCS 5/5-30d new)

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

20 ARTICLE 999.

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