**Section 140.461 Clinic Participation, Data and Certification Requirements**

a) Hospital-based organized clinics must:

1) Have an administrative structure, staff program, physical setting, and equipment to provide comprehensive medical care.

2) Agree to assume complete responsibility for diagnosis and treatment of the patients accepted by the clinic, or provide, at no additional cost to the Department, for the acquisition of these services through contractual arrangements with external medical providers.

3) Meet one of the following requirements:

A) Be adjacent to or on the premises of a hospital:

i) licensed under the Hospital Licensing Act or the University of Illinois Hospital Act; or

ii) that meets all comparable conditions and requirements of the Hospital Licensing Act in effect for the state in which it is located.

B) Have provider-based status under Medicare pursuant to 42 CFR 413.65.

C) Be clinically integrated as evidenced by all of the following:

i) Professional staff of the clinic have clinical privileges at the main hospital; the main hospital maintains the same monitoring and oversight of the clinic as it does for any other department of the hospital; medical staff committees or other professional committees at the main hospital are responsible for medical activities in the clinic, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the clinic and the main hospital; medical records for patients treated in the clinic are integrated into a unified retrieval system of the main hospital, or cross reference that retrieval system; and inpatient and outpatient services of the clinic and the main hospital are integrated, and patients treated at the clinic who require further care have full access to all services of the main hospital and are referred when appropriate to the corresponding inpatient or outpatient department or service of the main hospital.

ii) Fully integrated within the financial system of the main hospital, as evidenced by shared income and expenses between the main hospital and the clinic.

iii) Held out to the public and other payers as part of the main hospital.

iv) Operated under the ownership and control of the main hospital, as evidenced by the following: the business enterprise that constitutes the clinic is 100 percent owned by the main hospital; the main hospital and the clinic have the same governing body; the clinic is operated under the same organizational documents (e.g., bylaws and operating decisions) as the main hospital; and the main hospital has final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the clinic.

v) Located within a 35 mile radius of the main hospital campus as defined in 42 CFR 413.65.

4) Meet the applicable requirements of 89 Ill. Adm. Code 148.40(d).

b) Encounter Rate Clinics

1) Encounter rate clinics must:

A) have participated in the Medical Assistance Program as an encounter rate clinic as of July 1, 1998; or

B) be a clinic operated by an Illinois county with a population of over three million.

2) Individual practitioners associated with these clinics may apply for participation in the Medical Assistance Program in their individual capacities. In order to participate in the Maternal and Child Health Program, as described in Subpart G, encounter rate clinics shall be required to meet the additional participation requirements described in Section 140.924(a)(2).

c) Rural health clinics must be certified by the Centers for Medicare and Medicaid Services as meeting the requirements for Medicare participation.

d) Federally Qualified Health Centers (FQHC):

1) Must meet one of the following criteria:

A) Receive a grant under Section 329, 330 or 340 of the Public Health Service Act (42 USC 329, 330 or 340).

B) Based on the recommendation of the Health Resources and Services Administration within the U.S. Department of Health and Human Services, be determined to meet the requirements for receiving a grant.

2) Section 1902(a)(55) of the Social Security Act (42 USC 1396a(a)(55)), requires states to receive and initially process Medicaid applications from low-income pregnant women and children under 19 years of age at locations other than the local Department of Human Services (DHS) office. These sites are referred to as outstations.

A) Outstations will be located at those FQHCs that the Department determines serve heavy Medicaid populated areas. For areas in which the Department determines that maintaining outstation workers is not economical, the DHS Family Community Resource Center (FCRC) will continue to be the application location.

B) The FQHCs, which will provide outstation eligibility staff to accept and assist in the initial processing of the Medicaid application for pregnant women and children, will forward the completed application to the appropriate DHS FCRC. Initial processing means accepting and completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete and conducting any necessary interviews. Neither the FQHCs nor the outstation workers will evaluate the information contained on the application, nor make any determination of eligibility or ineligibility. The DHS FCRC is responsible for these functions.

C) Costs allowable under the federal outstation mandate for completing the Medicaid application will be itemized in Section B of Schedule I of the FQHC Medicaid cost report and will be provided annually in the FQHC cost reporting process. These allowable costs will be collected, computed and calculated, and will result in the establishment of an outstation administrative rate and a Medicaid rate. The allowable costs are:

i) Salary of outstation worker.

ii) Fringe benefits.

iii) Training.

iv) Travel.

v) Supplies.

D) FQHC outstation workers must receive certification through Maternal and Child Health (MCH) process training by the Department before they begin to perform eligibility processing functions. Failure to become certified results in any MCH application completed by an ineligible worker being non-allowed on the cost report.

E) FQHCs must have adequate staff trained with proper backup to accommodate unforeseen problems. FQHCs must be able to meet the demand of this initiative, either using staff at one location or rotating staff as dictated by workload or staffing availability. The FQHC must have staff available at each outstation location during regular office operating hours.

F) Outstation intake staff may perform other FQHC intake processing functions, but the time spent on outstation activities must be documented and must be identifiable for cost reporting and auditing purposes.

G) The FQHC must display a notice in a prominent place at the outstation location advising potential applicants of the times that outstation intake workers will be available. The notice must include a telephone number that applicants may call for assistance.

H) The FQHC must comply with federal and State laws and regulations governing the provision of adequate notice to persons who are blind or deaf or who are unable to read or understand the English language.

e) Individual practitioners associated with such centers may apply for participation in the Medical Assistance Program in their individual capacities.

f) School Based/Linked Health Clinics (centers) must be certified by the Department of Human Services (DHS) that they are meeting the minimum standards established by DHS (77 Ill. Adm. Code 2200). Examples of certification requirements include:

1) School based health centers must be located in schools or on school grounds, serving at least the students attending that school.

2) School linked health centers are located off school grounds, but a formal relationship must exist to serve students attending a particular school or multiple schools within the district.

3) All medical services performed by mid-level practitioners (i.e., medical services providers who are not physicians), such as nurse practitioners, must be under the direction of a physician.

4) The center must have a medical director. The medical director of the center must be a qualified physician, licensed in Illinois to practice medicine in all its branches. Each center's medical director must develop standing orders and protocols for services provided at the center. The medical director shall ensure compliance with the policies and procedures pertaining to medical procedures and health care services. The medical director shall supervise the medical protocols involving direct care of students. The center must have consultant or back-up physicians with hospital admitting privileges. The consultant provider of the clinic for obstetrical care, as appropriate, must have delivery privileges. All medical services must be delivered in accordance with the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Practice Guidelines and the standards established by outside regulatory agencies.

5) All laboratory services must be in compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (42 USC 263a). DHS will provide ongoing monitoring to assure that appropriate standards are followed.

6) The center shall be staffed by Illinois licensed, registered, and/or certified health professionals who are trained and experienced in community and school health, and who have knowledge of health promotion and illness prevention strategies for children and adolescents. The center must ensure that staff are assigned responsibilities consistent with their education and experience, supervised, evaluated annually and trained in the policies and procedures of the center.

7) The center must establish procedures for the availability of primary care providers and for 24-hour per day, 12-month per year access to routine, urgent and emergency care, telephone appointments and advice. The center must have in place telephone answering methods that notify students and parents/guardians where and how to access 24-hour back-up services when the center is not open.

8) Services may be provided to eligible students who have obtained written parental consent, or who are 18 years of age, and/or who are otherwise able to give their own consent.

9) The center must coordinate care and the exchange of information necessary for the provision of health care of the student, between the center and a student's primary care practitioner, medical specialist or managed care entity. Written policies must address obtaining student and/or parental consent to share information regarding a student's health care.

10) The center must operate in accordance with a systematic process for referring students to community-based health care providers when the center is not able to provide the services required by the student. The center may provide medical care to a Managed Care Entity (MCE) enrolled student. The center shall refer that MCE enrolled student to the MCE primary care provider for continuing and definitive care.

A) The center shall refer a student who requires specialty medical and/or surgical services to his or her primary care provider or MCE to obtain a referral for a specialist.

B) The center shall document in the student's record that the referral was made, and document follow-up on the outcome of the referral when relevant to the health care provided by the center.

11) The center must develop a collaborative relationship with other health care providers, insurers, managed care organizations, the school health program, students and parents or guardians with the goal of assuring continuity of care, pertinent medical record sharing and reducing duplication and fragmentation of services.

12) Data Requirements

The center shall maintain a health record system that provides for consistency, confidentiality, storage and security of records for documenting significant student health information and the delivery of health care services.

g) Hospital Outpatient Departments

Hospital outpatient departments may include facilities that meet the requirements of subsection (a)(3) of this Section.

h) County-operated Outpatient Facilities

A county-operated outpatient facility is a non-hospital-based clinic operated by and located in an Illinois county with a population exceeding three million.

1) Critical Clinic Providers. A critical clinic provider is a county-operated outpatient facility that is within or adjacent to a large public hospital as defined in 89 Ill. Adm. Code 148.25(a)(1).

2) County Ambulatory Health Centers. A county ambulatory health center is a county-operated outpatient facility that is not a critical clinic provider.

3) County-operated outpatient facilities shall submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

(Source: Amended at 38 Ill. Reg. 15081, effective July 2, 2014)