AN ACT concerning public aid.

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

Section 5. The Department of Healthcare and Family Services Law of the Civil Administrative Code of Illinois is amended by changing Section 2205-30 as follows:

(20 ILCS 2205/2205-30)

(Section scheduled to be repealed on December 1, 2020)

Sec. 2205-30. Long-term care services and supports comprehensive study and actuarial modeling.

(a) The Department of Healthcare and Family Services shall commission a comprehensive study of long-term care trends, future projections, and actuarial analysis of a new long-term services and supports benefit. Upon completion of the study, the Department shall prepare a report on the study that includes the following:

(1) an extensive analysis of long-term care trends in Illinois, including the number of Illinoisans needing long-term care, the number of paid and unpaid caregivers, the existing long-term care programs' utilization and impact on the State budget; out-of-pocket spending and spend-down to qualify for medical assistance coverage, the financial and health impacts of caregiving on the family,

wages of paid caregivers and the effects of compensation on the availability of this workforce, the current market for private long-term care insurance, and a brief assessment of the existing system of long-term services and supports in terms of health, well-being, and the ability of participants to continue living in their communities;

(2) an analysis of long-term care costs and utilization projections through at least 2050 and the estimated impact of such costs and utilization projections on the State budget, increases in the senior population; projections of the number of paid and unpaid caregivers in relation to demand for services, and projections of the impact of housing cost burdens and a lack of affordable housing on seniors and people with disabilities;

(3) an actuarial analysis of options for a new long-term services and supports benefit program, including an analysis of potential tax sources and necessary levels, a vesting period, the maximum daily benefit dollar amount, the total maximum dollar amount of the benefit, and the duration of the benefit; and

(4) a qualitative analysis of a new benefit's impact on seniors and people with disabilities, including their families and caregivers, public and private long-term care services, and the State budget.

The report must project under multiple possible configurations the numbers of persons covered year over year,

utilization rates, total spending, and the benefit fund's ratio balance and solvency. The benefit fund must initially be structured to be solvent for 75 years. The report must detail the sensitivity of these projections to the level of care criteria that define long-term care need and examine the feasibility of setting a lower threshold, based on a lower need for ongoing assistance in routine life activities.

The report must also detail the amount of out-of-pocket costs avoided, the number of persons who delayed or avoided utilization of medical assistance benefits, an analysis on the projected increased utilization of home-based and community-based services over skilled nursing facilities and savings therewith, and savings to the State's existing long-term care programs due to the new long-term services and supports benefit.

(b) The entity chosen to conduct the actuarial analysis shall be a nationally-recognized organization with experience modeling public and private long-term care financing programs.

(c) The study shall begin after January 1, 2019, and be completed before December 1, 2020 ~~2019~~. Upon completion, the report on the study shall be filed with the Clerk of the House of Representatives and the Secretary of the Senate in electronic form only, in the manner that the Clerk and the Secretary shall direct.

(d) This Section is repealed December 1, 2020.

(Source: P.A. 100-587, eff. 6-4-18.)

Section 10. The Illinois Procurement Code is amended by adding Section 20-25.1 as follows:

(30 ILCS 500/20-25.1 new)

Sec. 20-25.1. Special expedited procurement.

(a) The Chief Procurement Officer shall work with the Department of Healthcare and Family Services to identify an appropriate method of source selection that will result in an executed contract for the technology required by Section 5-30.12 of the Illinois Public Aid Code no later than August 1, 2019 in order to target implementation of the technology to be procured by January 1, 2020. The method of source selection may be sole source, emergency, or other expedited process.

(b) Due to the negative impact on access to critical State health care services and the ability to draw federal match for services being reimbursed caused by issues with implementation of the Integrated Eligibility System by the Department of Human Services, the Department of Healthcare and Family Services, and the Department of Innovation and Technology, the General Assembly finds that a threat to public health exists and to prevent or minimize serious disruption in critical State services that affect health, an emergency purchase of a vendor shall be made by the Department of Healthcare and Family Services to assess the Integrated Eligibility System for critical gaps and processing errors and to monitor the

performance of the Integrated Eligibility System vendor under the terms of its contract. The emergency purchase shall not exceed 2 years. Notwithstanding any other provision of this Code, such emergency purchase shall extend without a hearing required by Section 20-30 until the integrated eligibility system is stabilized and performing according to the needs of the State to ensure continued access to health care for eligible individuals.

Section 30. The Children's Health Insurance Program Act is amended by changing Section 7 as follows:

(215 ILCS 106/7)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

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

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

the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send a notice to the recipient at least 60 days prior to the end of the period of eligibility that informs them of the requirements for continued eligibility. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-health care

benefits, that is sufficient to make a determination of continued eligibility for medical assistance or for benefits provided under the Program may be reviewed and verified, and subsequent action taken including client notification of continued eligibility for medical assistance or for benefits provided under the Program. The date of client notification establishes the date for subsequent annual eligibility reviews. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end no later than the last day of the month following ~~on~~ the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

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

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment

Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

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

(Source: P.A. 98-651, eff. 6-16-14.)

Section 35. The Covering ALL KIDS Health Insurance Act is amended by changing Section 7 as follows:

(215 ILCS 170/7)

(Section scheduled to be repealed on October 1, 2019)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be

determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

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

(1) By July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants to the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.

(2) By October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described

in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-health care benefits, that is sufficient to make a determination of continued eligibility for benefits provided under this Act, the Children's Health Insurance Program Act, or Article V of the Illinois Public Aid Code may be reviewed and verified, and subsequent action taken including client notification of continued eligibility for benefits provided under this Act, the Children's Health Insurance Program Act, or Article V of the Illinois Public Aid Code. The date of client notification establishes the date for subsequent annual eligibility reviews. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end no later than the last day of the month following ~~on~~ the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the

requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By July 1, 2011, require verification of Illinois residency.

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

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients

informing them of the changes regarding their eligibility verification.

(Source: P.A. 98-651, eff. 6-16-14.)

Section 40. The Illinois Public Aid Code is amended by changing Sections 5-4.1, 5-5, 5-5f, 5-30.1, 5A-4, 11-5.1, 11-5.3, 11-5.4, and 12-4.42 and by adding Sections 5-5.10, 5-30.11, 5-30.12, and 14-13 as follows:

(305 ILCS 5/5-4.1) (from Ch. 23, par. 5-4.1)

Sec. 5-4.1. Co-payments. The Department may by rule provide that recipients under any Article of this Code shall pay a federally approved fee as a co-payment for services. No ~~provide that recipients under any Article of this Code shall pay a fee as a co-payment for services. Co-payments shall be maximized to the extent permitted by federal law, except that the Department shall impose a co pay of $2 on generic drugs. Provided, however, that any such rule must provide that no~~ co-payment requirement can exist for renal dialysis, radiation therapy, cancer chemotherapy, or insulin, and other products necessary on a recurring basis, the absence of which would be life threatening, or where co-payment expenditures for required services and/or medications for chronic diseases that the Illinois Department shall by rule designate shall cause an extensive financial burden on the recipient, and provided no co-payment shall exist for emergency room encounters which are

for medical emergencies. The Department shall seek approval of a State plan amendment that allows pharmacies to refuse to dispense drugs in circumstances where the recipient does not pay the required co-payment. Co-payments may not exceed $10 for emergency room use for a non-emergency situation as defined by the Department by rule and subject to federal approval.
(Source: P.A. 96-1501, eff. 1-25-11; 97-74, eff. 6-30-11; 97-689, eff. 6-14-12.)

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

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

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

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

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

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

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

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

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

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

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

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

person may select.

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

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

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

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

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

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

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

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

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

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

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

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

All screenings shall include a physical breast exam, instruction on self-examination and information regarding the frequency of self-examination and its value as a preventative tool. For purposes of this Section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with an average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis. As used in this Section, the term "breast

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

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

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

reimbursement for digital mammography.

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

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

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

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

The Department shall establish a methodology to remind women who are age-appropriate for screening mammography, but

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

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

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

served by the pilot program.

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

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

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

addition to treatment for addiction.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Enrollment of a vendor shall be subject to a provisional period and shall be conditional for one year. During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the medical assistance program without cause.

Unless otherwise specified, such termination of eligibility or disenrollment is not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

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

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

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

hearing rights, if any, afforded to a vendor in each category of risk of the vendor that is terminated or disenrolled during the conditional enrollment period.

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

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

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

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

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

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

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

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

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

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

federal agencies and departments, including but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

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

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

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

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

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

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

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the

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

care eligibility criteria for community-based services in circumstances where federal approval has been granted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Administration.

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

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

~~Notwithstanding any other provision of this Code, the Illinois Department shall authorize licensed dietitian nutritionists and certified diabetes educators to counsel senior diabetes patients in the senior diabetes patients' homes to remove the hurdle of transportation for senior diabetes~~

~~patients to receive treatment.~~

(Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for the effective date of P.A. 99-407); 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff. 12-10-18.)

(305 ILCS 5/5-5.10 new)

Sec. 5-5.10. Value-based purchasing.

(a) The Department of Healthcare and Family Services, and, as appropriate, divisions within the Department of Human Services, shall confer with stakeholders to discuss development of alternative value-based payment models that move away from fee-for-service and reward health outcomes and improved quality and provide flexibility in how providers meet the needs of the individuals they serve. Stakeholders include providers, managed care organizations, and community-based and advocacy organizations. The approaches explored may be different for different types of services.

(b) The Department of Healthcare and Family Services and the Department of Human Services shall initiate discussions

with mental health providers, substance abuse providers, managed care organizations, advocacy groups for individuals with behavioral health issues, and others, as appropriate, no later than July 1, 2019. A model for value-based purchasing for behavioral health providers shall be presented to the General Assembly by January 31, 2020. In developing this model, the Department of Healthcare and Family Services shall develop projections of the funding necessary for the model.

(305 ILCS 5/5-5f)

Sec. 5-5f. Elimination and limitations of medical assistance services. Notwithstanding any other provision of this Code to the contrary, on and after July 1, 2012:

(a) The following services shall no longer be a covered service available under this Code: group psychotherapy for residents of any facility licensed under the Nursing Home Care Act or the Specialized Mental Health Rehabilitation Act of 2013; and adult chiropractic services.

(b) The Department shall place the following limitations on services: (i) the Department shall limit adult eyeglasses to one pair every 2 years; however, the limitation does not apply to an individual who needs different eyeglasses following a surgical procedure such as cataract surgery; (ii) the Department shall set an annual limit of a maximum of 20 visits for each of the following services: adult speech, hearing, and language

therapy services, adult occupational therapy services, and physical therapy services; on or after October 1, 2014, the annual maximum limit of 20 visits shall expire but the Department may ~~shall~~ require prior approval for all individuals for speech, hearing, and language therapy services, occupational therapy services, and physical therapy services; (iii) the Department shall limit adult podiatry services to individuals with diabetes; on or after October 1, 2014, podiatry services shall not be limited to individuals with diabetes; (iv) the Department shall pay for caesarean sections at the normal vaginal delivery rate unless a caesarean section was medically necessary; (v) the Department shall limit adult dental services to emergencies; beginning July 1, 2013, the Department shall ensure that the following conditions are recognized as emergencies: (A) dental services necessary for an individual in order for the individual to be cleared for a medical procedure, such as a transplant; (B) extractions and dentures necessary for a diabetic to receive proper nutrition; (C) extractions and dentures necessary as a result of cancer treatment; and (D) dental services necessary for the health of a pregnant woman prior to delivery of her baby; on or after July 1, 2014, adult dental services shall no longer be limited to emergencies, and dental services necessary for the health of a pregnant woman prior to delivery of her baby shall continue to be

covered; and (vi) effective July 1, 2012, the Department shall place limitations and require concurrent review on every inpatient detoxification stay to prevent repeat admissions to any hospital for detoxification within 60 days of a previous inpatient detoxification stay. The Department shall convene a workgroup of hospitals, substance abuse providers, care coordination entities, managed care plans, and other stakeholders to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification, which shall be published on the Department's website no later than September 1, 2013.

(c) The Department shall require prior approval of the following services: wheelchair repairs costing more than $400, coronary artery bypass graft, and bariatric surgery consistent with Medicare standards concerning patient responsibility. Wheelchair repair prior approval requests shall be adjudicated within one business day of receipt of complete supporting documentation. Providers may not break wheelchair repairs into separate claims for purposes of staying under the $400 threshold for requiring prior approval. The wholesale price of manual and power wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

(d) The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a minimum, $40,000,000.

(e) The Department shall establish utilization controls for the hospice program such that it shall not pay for other care services when an individual is in hospice.

(f) For home health services, the Department shall require Medicare certification of providers participating in the program and implement the Medicare face-to-face encounter rule. The Department shall require providers to implement auditable electronic service verification based on global positioning systems or other cost-effective technology.

(g) For the Home Services Program operated by the

Department of Human Services and the Community Care Program operated by the Department on Aging, the Department of Human Services, in cooperation with the Department on Aging, shall implement an electronic service verification based on global positioning systems or other cost-effective technology.

(h) Effective with inpatient hospital admissions on or after July 1, 2012, the Department shall reduce the payment for a claim that indicates the occurrence of a provider-preventable condition during the admission as specified by the Department in rules. The Department shall not pay for services related to an other provider-preventable condition.

As used in this subsection (h):

"Provider-preventable condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 or an other provider-preventable condition.

"Other provider-preventable condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

(i) The Department shall implement cost savings initiatives for advanced imaging services, cardiac imaging services, pain management services, and back surgery. Such

initiatives shall be designed to achieve annual costs savings.

(j) The Department shall ensure that beneficiaries with a diagnosis of epilepsy or seizure disorder in Department records will not require prior approval for anticonvulsants.

(Source: P.A. 100-135, eff. 8-18-17.)

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

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

"Emergency services" include:

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

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

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

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

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

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

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

(1) the MCO authorized such services;

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

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

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated

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

(e) The following requirements apply to MCOs in determining payment for all emergency services:

(1) MCOs shall not impose any requirements for prior approval of emergency services.

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

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

(4) The MCO shall not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's screening and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the provider actually treating the enrollee, of whether an enrollee is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover emergency services for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider.

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

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

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

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

(D) the enrollee is discharged.

(f) Network adequacy and transparency.

(1) The Department shall:

(A) ensure that an adequate provider network is in

place, taking into consideration health professional shortage areas and medically underserved areas;

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

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

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

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

(g) Timely payment of claims.

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

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

(3) The MCO shall pay a penalty that is at least equal

to the timely payment interest penalty imposed under Section 368a of the Illinois Insurance Code for any claims not timely paid.

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

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

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

(B) Compliance with the expedited provider requirement may be satisfied by an MCO through the use of a Periodic Interim Payment (PIP) program that has been mutually agreed to and documented between the MCO and the provider, and the PIP program ensures that any expedited provider receives regular and periodic payments based on prior period payment

experience from that MCO. Total payments under the PIP program may be reconciled against future PIP payments on a schedule mutually agreed to between the MCO and the provider.

(C) The Department shall share at least monthly its expedited provider list and the frequency with which it pays providers on the expedited list. ~~The Department may establish a process for MCOs to expedite payments to providers based on criteria established by the Department.~~

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

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

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

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

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

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

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

~~(3)~~ The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

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

~~(4)~~ The rules shall be applicable for both MCO coverage and

fee-for-service coverage.

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

(g-6) MCO Performance Metrics Report.

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

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

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

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

(4) Metrics shall be defined and incorporated into the

applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

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

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

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

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

(A) Premium revenue, with appropriate adjustments.

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

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

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

(2) The medical loss ratio shall be calculated consistent with federal law and regulation following a claims runout

period determined by the Department.

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

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

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

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

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

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

enrollment subsystem within the IMPACT system. Such provider directory shall be readily accessible for purposes of selecting an approved health care provider and comply with all other federal and State requirements.

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

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended,

or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(j) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form that grants to the health care provider permission to release the recipient's health care information to the recipient's insurance carrier.

(Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16; 100-201, eff. 8-18-17; 100-580, eff. 3-12-18; 100-587, eff. 6-4-18.)

(305 ILCS 5/5-30.11 new)

Sec. 5-30.11. Managed care reports; minority-owned and women-owned businesses. Each Medicaid managed care health plan shall submit a report to the Department by March 1, 2020, and every March 1 thereafter, that includes the following information:

(1) The administrative expenses paid to the Medicaid managed care health plan.

(2) The amount of money the Medicaid managed care health plan has spent with Business Enterprise Program

certified businesses.

(3) The amount of money the Medicaid managed care health plan has spent with minority-owned and women-owned businesses that are certified by other agencies or private organizations.

(4) The amount of money the Medicaid managed care health plan has spent with not-for-profit community-based organizations serving predominantly minority communities, as defined by the Department.

(5) The proportion of minorities, people with disabilities, and women that make up the staff of the Medicaid managed care health plan.

(6) Recommendations for increasing expenditures with minority-owned and women-owned businesses.

(7) A list of the types of services to which the Medicaid managed care health plan is contemplating adding new vendors.

(8) The certifications the Medicaid managed care health plan accepts for minority-owned and women-owned businesses.

(9) The point of contact for potential vendors seeking to do business with the Medicaid managed care health plan.

The Department shall publish the reports on its website and shall maintain each report on its website for 5 years. In May of 2020 and every May thereafter, the Department shall hold 2 annual public workshops, one in Chicago and one in Springfield.

The workshops shall include each Medicaid managed care health plan and shall be open to vendor communities to discuss the submitted plans and to seek to connect vendors with the Medicaid managed care health plans.

(305 ILCS 5/5-30.12 new)

Sec. 5-30.12. Managed care claim rejection and denial management.

(a) In order to provide greater transparency to managed care organizations (MCOs) and providers, the Department shall explore the availability of and, if reasonably available, procure technology that, for all electronic claims, with the exception of direct data entry claims, meets the following needs:

(1) The technology shall allow the Department to fully analyze the root cause of claims denials in the Medicaid managed care programs operated by the Department and expedite solutions that reduce the number of denials to the extent possible.

(2) The technology shall create a single electronic pipeline through which all claims from all providers submitted for adjudication by the Department or a managed care organization under contract with the Department shall be directed by clearing houses and providers or other claims submitting entities not using clearing houses prior to forwarding to the Department or the appropriate managed

care organization.

(3) The technology shall cause all HIPAA-compliant responses to submitted claims, including rejections, denials, and payments, returned to the submitting provider to pass through the established single pipeline.

(4) The technology shall give the Department the ability to create edits to be placed at the front end of the pipeline that will reject claims back to the submitting provider with an explanation of why the claim cannot be properly adjudicated by the payer.

(5) The technology shall allow the Department to customize the language used to explain why a claim is being rejected and how the claim can be corrected for adjudication.

(6) The technology shall send copies of all claims and claim responses that pass through the pipeline, regardless of the payer to whom they are directed, to the Department's Enterprise Data Warehouse.

(b) If the Department chooses to implement front end edits or customized responses to claims submissions, the MCOs and other stakeholders shall be consulted prior to implementation and providers shall be notified of edits at least 30 days prior to their effective date.

(c) Neither the technology nor MCO policy shall require providers to submit claims through a process other than the pipeline. MCOs may request supplemental information needed for

adjudication which cannot be contained in the claim file to be submitted separately to the MCOs.

(d) The technology shall allow the Department to fully analyze and report on MCO claims processing and payment performance by provider type.

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

Sec. 5A-4. Payment of assessment; penalty.

(a) The assessment imposed by Section 5A-2 for State fiscal year 2009 through State fiscal year 2018 or as provided in Section 5A-16, shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the fourteenth State business day of each month. No installment payment of an assessment imposed by Section 5A-2 shall be due and payable, however, until after the Comptroller has issued the payments required under this Article.

Except as provided in subsection (a-5) of this Section, the assessment imposed by subsection (b-5) of Section 5A-2 for the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012, and for State fiscal year 2013 through State fiscal year 2018 or as provided in Section 5A-16, shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the 17th State business day of each month. No installment payment of an assessment imposed by subsection (b-5) of Section 5A-2 shall be due and payable, however, until after: (i) the Department

notifies the hospital provider, in writing, that the payment methodologies to hospitals required under Section 5A-12.4, have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, and the waiver under 42 CFR 433.68 for the assessment imposed by subsection (b-5) of Section 5A-2, if necessary, has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and (ii) the Comptroller has issued the payments required under Section 5A-12.4. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12.4 and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under subsection (b-5) of Section 5A-2 prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.4.

Except as provided in subsection (a-5) of this Section, the assessment imposed under Section 5A-2 for State fiscal year 2019 and each subsequent State fiscal year shall be due and payable in monthly installments, each equaling one-twelfth of the assessment for the year, on the 17th ~~14th~~ State business day of each month. No installment payment of an assessment imposed by Section 5A-2 shall be due and payable, however, until after: (i) the Department notifies the hospital provider, in writing, that the payment methodologies to hospitals

required under Section 5A-12.6 have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, and the waiver under 42 CFR 433.68 for the assessment imposed by Section 5A-2, if necessary, has been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services; and (ii) the Comptroller has issued the payments required under Section 5A-12.6. Upon notification to the Department of approval of the payment methodologies required under Section 5A-12.6 and the waiver granted under 42 CFR 433.68, if necessary, all installments otherwise due under Section 5A-2 prior to the date of notification shall be due and payable to the Department upon written direction from the Department and issuance by the Comptroller of the payments required under Section 5A-12.6.

(a-5) The Illinois Department may accelerate the schedule upon which assessment installments are due and payable by hospitals with a payment ratio greater than or equal to one. Such acceleration of due dates for payment of the assessment may be made only in conjunction with a corresponding acceleration in access payments identified in Section 5A-12.2, Section 5A-12.4, or Section 5A-12.6 to the same hospitals. For the purposes of this subsection (a-5), a hospital's payment ratio is defined as the quotient obtained by dividing the total payments for the State fiscal year, as authorized under Section 5A-12.2, Section 5A-12.4, or Section 5A-12.6, by the total

assessment for the State fiscal year imposed under Section 5A-2 or subsection (b-5) of Section 5A-2.

(b) The Illinois Department is authorized to establish delayed payment schedules for hospital providers that are unable to make installment payments when due under this Section due to financial difficulties, as determined by the Illinois Department.

(c) If a hospital provider fails to pay the full amount of an installment when due (including any extensions granted under subsection (b)), there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5A-2 a penalty assessment equal to the lesser of (i) 5% of the amount of the installment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each 30-day period thereafter or (ii) 100% of the installment amount not paid on or before the due date. For purposes of this subsection, payments will be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

(d) Any assessment amount that is due and payable to the Illinois Department more frequently than once per calendar quarter shall be remitted to the Illinois Department by the hospital provider by means of electronic funds transfer. The Illinois Department may provide for remittance by other means if (i) the amount due is less than $10,000 or (ii) electronic

funds transfer is unavailable for this purpose.

(Source: P.A. 100-581, eff. 3-12-18; 100-1181, eff. 3-8-19.)

(305 ILCS 5/11-5.1)

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

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

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

(2) By no later than October 1, 2011, require

verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility for medical assistance under this Code. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-Medicaid benefits, that is sufficient to make a determination of continued Medicaid eligibility may be reviewed and verified, and subsequent action taken including client notification of continued Medicaid eligibility. The date of client notification establishes the date for subsequent annual Medicaid eligibility reviews. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice a

notice of cancellation shall be issued to the recipient and coverage shall end no later than the last day of the month following ~~on~~ the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

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

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

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

or current recipients of health benefits under the Program. Data shall be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

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

(d) As soon as practical if the data is reasonably available, but no later than January 1, 2017, the Department shall compile on a monthly basis data on eligibility redeterminations of beneficiaries of medical assistance provided under Article V of this Code. This data shall be posted on the Department's website, and data from prior months shall be retained and available on the Department's website. The data compiled and reported shall include the following:

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

(2) A breakdown of enrollee language preference for the total number of redetermination decisions made in a month and, of that total number, a breakdown of enrollee language preference for the number of decisions to continue or

change benefits, and a breakdown of enrollee language preference for the number of decisions to cancel benefits. The language breakdown shall include, at a minimum, English, Spanish, and the next 4 most commonly used languages.

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

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

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

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

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

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

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

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

(4) If a vendor is utilized to provide services in

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

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

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

(1) Recipients of developmental disabilities services.

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

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

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

(5) Populations with no verifiable income.

(6) Self-employed people.

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

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

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

(h) Reporting. The Department of Healthcare and Family Services and the Department of Human Services shall publish

quarterly reports on their progress in implementing policies and practices pursuant to this Section as modified by this amendatory Act of the 101st General Assembly.

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

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

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

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

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

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

(Source: P.A. 98-651, eff. 6-16-14; 99-86, eff. 7-21-15.)

(305 ILCS 5/11-5.3)

Sec. 11-5.3. Procurement of vendor to verify eligibility for assistance under Article V.

(a) No later than 60 days after the effective date of this amendatory Act of the 97th General Assembly, the Chief Procurement Officer for General Services, in consultation with the Department of Healthcare and Family Services, shall conduct and complete any procurement necessary to procure a vendor to verify eligibility for assistance under Article V of this Code. Such authority shall include procuring a vendor to assist the Chief Procurement Officer in conducting the procurement. The Chief Procurement Officer and the Department shall jointly negotiate final contract terms with a vendor selected by the Chief Procurement Officer. Within 30 days of selection of an eligibility verification vendor, the Department of Healthcare and Family Services shall enter into a contract with the selected vendor. The Department of Healthcare and Family Services and the Department of Human Services shall cooperate with and provide any information requested by the Chief Procurement Officer to conduct the procurement.

(b) Notwithstanding any other provision of law, any procurement or contract necessary to comply with this Section shall be exempt from: (i) the Illinois Procurement Code pursuant to Section 1-10(h) of the Illinois Procurement Code,

except that bidders shall comply with the disclosure requirement in Sections 50-10.5(a) through (d), 50-13, 50-35, and 50-37 of the Illinois Procurement Code and a vendor awarded a contract under this Section shall comply with Section 50-37 of the Illinois Procurement Code; (ii) any administrative rules of this State pertaining to procurement or contract formation; and (iii) any State or Department policies or procedures pertaining to procurement, contract formation, contract award, and Business Enterprise Program approval.

(c) Upon becoming operational, the contractor shall conduct data matches using the name, date of birth, address, and Social Security Number of each applicant and recipient against public records to verify eligibility. The contractor, upon preliminary determination that an enrollee is eligible or ineligible, shall notify the Department, except that the contractor shall not make preliminary determinations regarding the eligibility of persons residing in long term care facilities whose income and resources were at or below the applicable financial eligibility standards at the time of their last review. Within 20 business days of such notification, the Department shall accept the recommendation or reject it with a stated reason. The Department shall retain final authority over eligibility determinations. The contractor shall keep a record of all preliminary determinations of ineligibility communicated to the Department. Within 30 days of the end of each calendar quarter, the Department and contractor shall file

a joint report on a quarterly basis to the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the Senate President, and the Senate Minority Leader. The report shall include, but shall not be limited to, monthly recommendations of preliminary determinations of eligibility or ineligibility communicated by the contractor, the actions taken on those preliminary determinations by the Department, and the stated reasons for those recommendations that the Department rejected.

(d) An eligibility verification vendor contract shall be awarded for an initial 2-year period with up to a maximum of 2 one-year renewal options. Nothing in this Section shall compel the award of a contract to a vendor that fails to meet the needs of the Department. A contract with a vendor to assist in the procurement shall be awarded for a period of time not to exceed 6 months.

(e) The provisions of this Section shall be administered in compliance with federal law.

(f) The State's Integrated Eligibility System shall be on a 3-year audit cycle by the Office of the Auditor General.

(Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13.)

(305 ILCS 5/11-5.4)

(Text of Section from P.A. 100-665)

Sec. 11-5.4. Expedited long-term care eligibility determination and enrollment.

(a) Establishment of the expedited long-term care eligibility determination and enrollment system shall be a joint venture of the Departments of Human Services and Healthcare and Family Services and the Department on Aging.

(b) Streamlined application enrollment process; expedited eligibility process. The streamlined application and enrollment process must include, but need not be limited to, the following:

(1) On or before July 1, 2019, a streamlined application and enrollment process shall be put in place which must include, but need not be limited to, the following:

(A) Minimize the burden on applicants by collecting only the data necessary to determine eligibility for medical services, long-term care services, and spousal impoverishment offset.

(B) Integrate online data sources to simplify the application process by reducing the amount of information needed to be entered and to expedite eligibility verification.

(C) Provide online prompts to alert the applicant that information is missing or not complete.

(D) Provide training and step-by-step written instructions for caseworkers, applicants, and providers.

(2) The State must expedite the eligibility process for

applicants meeting specified guidelines, regardless of the age of the application. The guidelines, subject to federal approval, must include, but need not be limited to, the following individually or collectively:

(A) Full Medicaid benefits in the community for a specified period of time.

(B) No transfer of assets or resources during the federally prescribed look-back period, as specified in federal law.

(C) Receives Supplemental Security Income payments or was receiving such payments at the time of admission to a nursing facility.

(D) For applicants or recipients with verified income at or below 100% of the federal poverty level when the declared value of their countable resources is no greater than the allowable amounts pursuant to Section 5-2 of this Code for classes of eligible persons for whom a resource limit applies. Such simplified verification policies shall apply to community cases as well as long-term care cases.

(3) Subject to federal approval, the Department of Healthcare and Family Services must implement an ex parte renewal process for Medicaid-eligible individuals residing in long-term care facilities. "Renewal" has the same meaning as "redetermination" in State policies, administrative rule, and federal Medicaid law. The ex parte

renewal process must be fully operational on or before January 1, 2019.

(4) The Department of Human Services must use the standards and distribution requirements described in this subsection and in Section 11-6 for notification of missing supporting documents and information during all phases of the application process: initial, renewal, and appeal.

(c) The Department of Human Services must adopt policies and procedures to improve communication between long-term care benefits central office personnel, applicants and their representatives, and facilities in which the applicants reside. Such policies and procedures must at a minimum permit applicants and their representatives and the facility in which the applicants reside to speak directly to an individual trained to take telephone inquiries and provide appropriate responses.

(d) Effective 30 days after the completion of 3 regionally based trainings, nursing facilities shall submit all applications for medical assistance online via the Application for Benefits Eligibility (ABE) website. This requirement shall extend to scanning and uploading with the online application any required additional forms such as the Long Term Care Facility Notification and the Additional Financial Information for Long Term Care Applicants as well as scanned copies of any supporting documentation. Long-term care facility admission documents must be submitted as required in Section 5-5 of this

Code. No local Department of Human Services office shall refuse to accept an electronically filed application. No Department of Human Services office shall request submission of any document in hard copy.

(e) Notwithstanding any other provision of this Code, the Department of Human Services and the Department of Healthcare and Family Services' Office of the Inspector General shall, upon request, allow an applicant additional time to submit information and documents needed as part of a review of available resources or resources transferred during the look-back period. The initial extension shall not exceed 30 days. A second extension of 30 days may be granted upon request. Any request for information issued by the State to an applicant shall include the following: an explanation of the information required and the date by which the information must be submitted; a statement that failure to respond in a timely manner can result in denial of the application; a statement that the applicant or the facility in the name of the applicant may seek an extension; and the name and contact information of a caseworker in case of questions. Any such request for information shall also be sent to the facility. In deciding whether to grant an extension, the Department of Human Services or the Department of Healthcare and Family Services' Office of the Inspector General shall take into account what is in the best interest of the applicant. The time limits for processing an application shall be tolled during the period of any

extension granted under this subsection.

(f) The Department of Human Services and the Department of Healthcare and Family Services must jointly compile data on pending applications, denials, appeals, and redeterminations into a monthly report, which shall be posted on each Department's website for the purposes of monitoring long-term care eligibility processing. The report must specify the number of applications and redeterminations pending long-term care eligibility determination and admission and the number of appeals of denials in the following categories:

(A) Length of time applications, redeterminations, and appeals are pending - 0 to 45 days, 46 days to 90 days, 91 days to 180 days, 181 days to 12 months, over 12 months to 18 months, over 18 months to 24 months, and over 24 months.

(B) Percentage of applications and redeterminations pending in the Department of Human Services' Family Community Resource Centers, in the Department of Human Services' long-term care hubs, with the Department of Healthcare and Family Services' Office of Inspector General, and those applications which are being tolled due to requests for extension of time for additional information.

(C) Status of pending applications, denials, appeals, and redeterminations.

(g) Beginning on July 1, 2017, the Auditor General shall report every 3 years to the General Assembly on the performance

and compliance of the Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging in meeting the requirements of this Section and the federal requirements concerning eligibility determinations for Medicaid long-term care services and supports, and shall report any issues or deficiencies and make recommendations. The Auditor General shall, at a minimum, review, consider, and evaluate the following:

(1) compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930;

(2) compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912;

(3) the accuracy and completeness of the report required under paragraph (9) of subsection (e);

(4) the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for long-term care services, including the role of the State's integrated eligibility system, as opposed to the traditional caseworker-specific process from which these central offices have converted; and

(5) any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of

the designated single-state Medicaid agency in Illinois, the Department of Healthcare and Family Services.

The Auditor General's report shall include any and all other areas or issues which are identified through an annual review. Paragraphs (1) through (5) of this subsection shall not be construed to limit the scope of the annual review and the Auditor General's authority to thoroughly and completely evaluate any and all processes, policies, and procedures concerning compliance with federal and State law requirements on eligibility determinations for Medicaid long-term care services and supports.

(h) The Department of Healthcare and Family Services shall adopt any rules necessary to administer and enforce any provision of this Section. Rulemaking shall not delay the full implementation of this Section.

(Source: P.A. 99-153, eff. 7-28-15; 100-380, eff. 8-25-17; 100-665, eff. 8-2-18.)

(Text of Section from P.A. 100-1141)

Sec. 11-5.4. Expedited long-term care eligibility determination and enrollment.

(a) An expedited long-term care eligibility determination and enrollment system shall be established to reduce long-term care determinations to 90 days or fewer by July 1, 2014 and streamline the long-term care enrollment process. Establishment of the system shall be a joint venture of the

Department of Human Services and Healthcare and Family Services and the Department on Aging. The Governor shall name a lead agency no later than 30 days after the effective date of this amendatory Act of the 98th General Assembly to assume responsibility for the full implementation of the establishment and maintenance of the system. Project outcomes shall include an enhanced eligibility determination tracking system accessible to providers and a centralized application review and eligibility determination with all applicants reviewed within 90 days of receipt by the State of a complete application. If the Department of Healthcare and Family Services' Office of the Inspector General determines that there is a likelihood that a non-allowable transfer of assets has occurred, and the facility in which the applicant resides is notified, an extension of up to 90 days shall be permissible. On or before December 31, 2015, a streamlined application and enrollment process shall be put in place based on the following principles:

(1) Minimize the burden on applicants by collecting only the data necessary to determine eligibility for medical services, long-term care services, and spousal impoverishment offset.

(2) Integrate online data sources to simplify the application process by reducing the amount of information needed to be entered and to expedite eligibility verification.

(3) Provide online prompts to alert the applicant that information is missing or not complete.

(b) The Department shall, on or before July 1, 2014, assess the feasibility of incorporating all information needed to determine eligibility for long-term care services, including asset transfer and spousal impoverishment financials, into the State's integrated eligibility system identifying all resources needed and reasonable timeframes for achieving the specified integration.

(c) The lead agency shall file interim reports with the Chairs and Minority Spokespersons of the House and Senate Human Services Committees no later than September 1, 2013 and on February 1, 2014. The Department of Healthcare and Family Services shall include in the annual Medicaid report for State Fiscal Year 2014 and every fiscal year thereafter information concerning implementation of the provisions of this Section.

(d) No later than August 1, 2014, the Auditor General shall report to the General Assembly concerning the extent to which the timeframes specified in this Section have been met and the extent to which State staffing levels are adequate to meet the requirements of this Section.

(e) The Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging shall take the following steps to achieve federally established timeframes for eligibility determinations for Medicaid and long-term care benefits and shall work toward the federal goal

of real time determinations:

(1) The Departments shall review, in collaboration with representatives of affected providers, all forms and procedures currently in use, federal guidelines either suggested or mandated, and staff deployment by September 30, 2014 to identify additional measures that can improve long-term care eligibility processing and make adjustments where possible.

(2) No later than June 30, 2014, the Department of Healthcare and Family Services shall issue vouchers for advance payments not to exceed $50,000,000 to nursing facilities with significant outstanding Medicaid liability associated with services provided to residents with Medicaid applications pending and residents facing the greatest delays. Each facility with an advance payment shall state in writing whether its own recoupment schedule will be in 3 or 6 equal monthly installments, as long as all advances are recouped by June 30, 2015.

(3) The Department of Healthcare and Family Services' Office of Inspector General and the Department of Human Services shall immediately forgo resource review and review of transfers during the relevant look-back period for applications that were submitted prior to September 1, 2013. An applicant who applied prior to September 1, 2013, who was denied for failure to cooperate in providing required information, and whose application was

incorrectly reviewed under the wrong look-back period rules may request review and correction of the denial based on this subsection. If found eligible upon review, such applicants shall be retroactively enrolled.

(4) As soon as practicable, the Department of Healthcare and Family Services shall implement policies and promulgate rules to simplify financial eligibility verification in the following instances: (A) for applicants or recipients who are receiving Supplemental Security Income payments or who had been receiving such payments at the time they were admitted to a nursing facility and (B) for applicants or recipients with verified income at or below 100% of the federal poverty level when the declared value of their countable resources is no greater than the allowable amounts pursuant to Section 5-2 of this Code for classes of eligible persons for whom a resource limit applies. Such simplified verification policies shall apply to community cases as well as long-term care cases.

(5) As soon as practicable, but not later than July 1, 2014, the Department of Healthcare and Family Services and the Department of Human Services shall jointly begin a special enrollment project by using simplified eligibility verification policies and by redeploying caseworkers trained to handle long-term care cases to prioritize those cases, until the backlog is eliminated and processing time

is within 90 days. This project shall apply to applications for long-term care received by the State on or before May 15, 2014.

(6) As soon as practicable, but not later than September 1, 2014, the Department on Aging shall make available to long-term care facilities and community providers upon request, through an electronic method, the information contained within the Interagency Certification of Screening Results completed by the pre-screener, in a form and manner acceptable to the Department of Human Services.

(7) Effective 30 days after the completion of 3 regionally based trainings, nursing facilities shall submit all applications for medical assistance online via the Application for Benefits Eligibility (ABE) website. This requirement shall extend to scanning and uploading with the online application any required additional forms such as the Long Term Care Facility Notification and the Additional Financial Information for Long Term Care Applicants as well as scanned copies of any supporting documentation. Long-term care facility admission documents must be submitted as required in Section 5-5 of this Code. No local Department of Human Services office shall refuse to accept an electronically filed application.

(8) Notwithstanding any other provision of this Code, the Department of Human Services and the Department of

Healthcare and Family Services' Office of the Inspector General shall, upon request, allow an applicant additional time to submit information and documents needed as part of a review of available resources or resources transferred during the look-back period. The initial extension shall not exceed 30 days. A second extension of 30 days may be granted upon request. Any request for information issued by the State to an applicant shall include the following: an explanation of the information required and the date by which the information must be submitted; a statement that failure to respond in a timely manner can result in denial of the application; a statement that the applicant or the facility in the name of the applicant may seek an extension; and the name and contact information of a caseworker in case of questions. Any such request for information shall also be sent to the facility. In deciding whether to grant an extension, the Department of Human Services or the Department of Healthcare and Family Services' Office of the Inspector General shall take into account what is in the best interest of the applicant. The time limits for processing an application shall be tolled during the period of any extension granted under this subsection.

(9) The Department of Human Services and the Department of Healthcare and Family Services must jointly compile data on pending applications, denials, appeals, and

redeterminations into a monthly report, which shall be posted on each Department's website for the purposes of monitoring long-term care eligibility processing. The report must specify the number of applications and redeterminations pending long-term care eligibility determination and admission and the number of appeals of denials in the following categories:

(A) Length of time applications, redeterminations, and appeals are pending - 0 to 45 days, 46 days to 90 days, 91 days to 180 days, 181 days to 12 months, over 12 months to 18 months, over 18 months to 24 months, and over 24 months.

(B) Percentage of applications and redeterminations pending in the Department of Human Services' Family Community Resource Centers, in the Department of Human Services' long-term care hubs, with the Department of Healthcare and Family Services' Office of Inspector General, and those applications which are being tolled due to requests for extension of time for additional information.

(C) Status of pending applications, denials, appeals, and redeterminations.

(f) Beginning on July 1, 2017, the Auditor General shall report every 3 years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services, the Department of Human Services, and the Department

on Aging in meeting the requirements of this Section and the federal requirements concerning eligibility determinations for Medicaid long-term care services and supports, and shall report any issues or deficiencies and make recommendations. The Auditor General shall, at a minimum, review, consider, and evaluate the following:

(1) compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930;

(2) compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912;

(3) the accuracy and completeness of the report required under paragraph (9) of subsection (e);

(4) the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for long-term care services, including the role of the State's integrated eligibility system, as opposed to the traditional caseworker-specific process from which these central offices have converted; and

(5) any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the designated single-state Medicaid agency in Illinois, the Department of Healthcare and Family Services.

The Auditor General's report shall include any and all other areas or issues which are identified through an annual review. Paragraphs (1) through (5) of this subsection shall not be construed to limit the scope of the annual review and the Auditor General's authority to thoroughly and completely evaluate any and all processes, policies, and procedures concerning compliance with federal and State law requirements on eligibility determinations for Medicaid long-term care services and supports.

(g) The Department shall adopt rules necessary to administer and enforce any provision of this Section. Rulemaking shall not delay the full implementation of this Section.

(h) Beginning on June 29, 2018, provisional eligibility for medical assistance under Article V of this Code, in the form of a recipient identification number and any other necessary credentials to permit an applicant to receive covered services under Article V ~~benefits~~, must be issued to any applicant who has not received a ~~final eligibility~~ determination on his or her application for Medicaid and Medicaid long-term care services filed simultaneously or, if already Medicaid enrolled, application for ~~or~~ Medicaid long-term care services under Article V of this Code ~~benefits or a notice of an opportunity for a hearing~~ within the federally prescribed timeliness requirements for determinations on ~~deadlines for the processing of~~ such applications. The Department must

maintain the applicant's provisional eligibility ~~Medicaid enrollment~~ status until a ~~final eligibility~~ determination is made on the individual's application for long-term care services ~~approved or the applicant's appeal has been adjudicated and eligibility is denied~~. The Department or the managed care organization, if applicable, must reimburse providers for services rendered during an applicant's provisional eligibility period.

(1) Claims for services rendered to an applicant with provisional eligibility status must be submitted and processed in the same manner as those submitted on behalf of beneficiaries determined to qualify for benefits.

(2) An applicant with provisional eligibility ~~enrollment~~ status must have his or her long-term care benefits paid for under the State's fee-for-service system during the period of provisional eligibility ~~until the State makes a final determination on the applicant's Medicaid or Medicaid long term care application~~. If an individual otherwise eligible for medical assistance under Article V of this Code is enrolled with a managed care organization for community benefits at the time the individual's provisional eligibility for long-term care services ~~status~~ is issued, the managed care organization is only responsible for paying benefits covered under the capitation payment received by the managed care organization for the individual.

(3) The Department, within 10 business days of issuing provisional eligibility to an applicant, must submit to the Office of the Comptroller for payment a voucher for all retroactive reimbursement due. The Department must clearly identify such vouchers as provisional eligibility vouchers.

(Source: P.A. 99-153, eff. 7-28-15; 100-380, eff. 8-25-17; 100-1141, eff. 11-28-18.)

(305 ILCS 5/12-4.42)

Sec. 12-4.42. Medicaid Revenue Maximization.

(a) Purpose. The General Assembly finds that there is a need to make changes to the administration of services provided by State and local governments in order to maximize federal financial participation.

(b) Definitions. As used in this Section:

"Community Medicaid mental health services" means all mental health services outlined in Part 132 of Title 59 of the Illinois Administrative Code that are funded through DHS, eligible for federal financial participation, and provided by a community-based provider.

"Community-based provider" means an entity enrolled as a provider pursuant to Sections 140.11 and 140.12 of Title 89 of the Illinois Administrative Code and certified to provide community Medicaid mental health services in accordance with Part 132 of Title 59 of the Illinois Administrative Code.

"DCFS" means the Department of Children and Family Services.

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

"Care facility for persons with a developmental disability" means an intermediate care facility for persons with an intellectual disability within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.

"Care provider for persons with a developmental disability" means a person conducting, operating, or maintaining a care facility for persons with a developmental disability. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

"DHS" means the Illinois Department of Human Services.

"Hospital" means an institution, place, building, or agency located in this State that is licensed as a general acute hospital by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

"Long term care facility" means (i) a skilled nursing or

intermediate long term care facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code, and (ii) a part of a hospital in which skilled or intermediate long term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided; except that the term "long term care facility" does not include a facility operated solely as an intermediate care facility for the intellectually disabled within the meaning of Title XIX of the Social Security Act.

"Long term care provider" means (i) a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long term care facility or (ii) a hospital provider that provides skilled or intermediate long term care services within the meaning of Title XVIII or XIX of the Social Security Act. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

"State-operated facility for persons with a developmental disability" means an intermediate care facility for persons

with an intellectual disability within the meaning of Title XIX of the Social Security Act operated by the State.

(c) Administration and deposit of Revenues. The Department shall coordinate the implementation of changes required by Public Act 96-1405 amongst the various State and local government bodies that administer programs referred to in this Section.

Revenues generated by program changes mandated by any provision in this Section, less reasonable administrative costs associated with the implementation of these program changes, which would otherwise be deposited into the General Revenue Fund shall be deposited into the Healthcare Provider Relief Fund.

The Department shall issue a report to the General Assembly detailing the implementation progress of Public Act 96-1405 as a part of the Department's Medical Programs annual report for fiscal years 2010 and 2011.

(d) Acceleration of payment vouchers. To the extent practicable and permissible under federal law, the Department shall create all vouchers for long term care facilities and facilities for persons with a developmental disability for dates of service in the month in which the enhanced federal medical assistance percentage (FMAP) originally set forth in the American Recovery and Reinvestment Act (ARRA) expires and for dates of service in the month prior to that month and shall, no later than the 15th of the month in which the

enhanced FMAP expires, submit these vouchers to the Comptroller for payment.

The Department of Human Services shall create the necessary documentation for State-operated facilities for persons with a developmental disability so that the necessary data for all dates of service before the expiration of the enhanced FMAP originally set forth in the ARRA can be adjudicated by the Department no later than the 15th of the month in which the enhanced FMAP expires.

(e) Billing of DHS community Medicaid mental health services. No later than July 1, 2011, community Medicaid mental health services provided by a community-based provider must be billed directly to the Department.

(f) DCFS Medicaid services. The Department shall work with DCFS to identify existing programs, pending qualifying services, that can be converted in an economically feasible manner to Medicaid in order to secure federal financial revenue.

(g) (Blank). ~~Third Party Liability recoveries. The Department shall contract with a vendor to support the Department in coordinating benefits for Medicaid enrollees. The scope of work shall include, at a minimum, the identification of other insurance for Medicaid enrollees and the recovery of funds paid by the Department when another payer was liable. The vendor may be paid a percentage of actual cash recovered when practical and subject to federal law.~~

(h) Public health departments. The Department shall identify unreimbursed costs for persons covered by Medicaid who are served by the Chicago Department of Public Health.

The Department shall assist the Chicago Department of Public Health in determining total unreimbursed costs associated with the provision of healthcare services to Medicaid enrollees.

The Department shall determine and draw the maximum allowable federal matching dollars associated with the cost of Chicago Department of Public Health services provided to Medicaid enrollees.

(i) Acceleration of hospital-based payments. The Department shall, by the 10th day of the month in which the enhanced FMAP originally set forth in the ARRA expires, create vouchers for all State fiscal year 2011 hospital payments exempt from the prompt payment requirements of the ARRA. The Department shall submit these vouchers to the Comptroller for payment.

(Source: P.A. 99-143, eff. 7-27-15; 100-201, eff. 8-18-17.)

(305 ILCS 5/14-13 new)

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

(a) By October 1, 2019, the Department shall by rule implement a methodology effective for dates of service July 1, 2019 and later to reimburse hospitals for inpatient stays

extended beyond medical necessity due to the inability of the Department or the managed care organization in which a recipient is enrolled or the hospital discharge planner to find an appropriate placement after discharge from the hospital.

(b) The methodology shall provide reasonable compensation for the services provided attributable to the days of the extended stay for which the prevailing rate methodology provides no reimbursement. The Department may use a day outlier program to satisfy this requirement. The reimbursement rate shall be set at a level so as not to act as an incentive to avoid transfer to the appropriate level of care needed or placement, after discharge.

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

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

(e) For services covered by the fee-for-service program, reimbursement under this Section shall only be made for days beyond medical necessity that occur after the hospital has

notified the Department of the need for post-discharge placement. For services covered by a managed care organization, hospitals shall notify the appropriate managed care organization of an admission within 24 hours of admission. For every 24-hour period beyond the initial 24 hours after admission that the hospital fails to notify the managed care organization of the admission, reimbursement under this subsection shall be reduced by one day.

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

(305 ILCS 5/5-5.07)

Sec. 5-5.07. Inpatient psychiatric stay; DCFS per diem rate. The Department of Children and Family Services shall pay the DCFS per diem rate for inpatient psychiatric stay at a free-standing psychiatric hospital effective the 11th day when a child is in the hospital beyond medical necessity, and the parent or caregiver has denied the child access to the home and has refused or failed to make provisions for another living arrangement for the child or the child's discharge is being delayed due to a pending inquiry or investigation by the Department of Children and Family Services. If any portion of a hospital stay is reimbursed under this Section, the hospital stay shall not be eligible for payment under the provisions of Section 14-13 of this Code. This Section is inoperative on and

after July 1, 2020. ~~This Section is repealed 6 months after the effective date of this amendatory Act of the 100th General Assembly.~~

(Source: P.A. 100-646, eff. 7-27-18.)

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