



Rep. Gregory Harris

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1 AMENDMENT TO SENATE BILL 1321

2 AMENDMENT NO. _____. Amend Senate Bill 1321 by replacing
3 everything after the enacting clause with the following:

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

7 (20 ILCS 2205/2205-30)

8 (Section scheduled to be repealed on December 1, 2020)

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

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

1 (1) an extensive analysis of long-term care trends in
2 Illinois, including the number of Illinoisans needing
3 long-term care, the number of paid and unpaid caregivers,
4 the existing long-term care programs' utilization and
5 impact on the State budget; out-of-pocket spending and
6 spend-down to qualify for medical assistance coverage, the
7 financial and health impacts of caregiving on the family,
8 wages of paid caregivers and the effects of compensation on
9 the availability of this workforce, the current market for
10 private long-term care insurance, and a brief assessment of
11 the existing system of long-term services and supports in
12 terms of health, well-being, and the ability of
13 participants to continue living in their communities;

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

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

1 duration of the benefit; and

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

6 The report must project under multiple possible
7 configurations the numbers of persons covered year over year,
8 utilization rates, total spending, and the benefit fund's ratio
9 balance and solvency. The benefit fund must initially be
10 structured to be solvent for 75 years. The report must detail
11 the sensitivity of these projections to the level of care
12 criteria that define long-term care need and examine the
13 feasibility of setting a lower threshold, based on a lower need
14 for ongoing assistance in routine life activities.

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

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

26 (c) The study shall begin after January 1, 2019, and be

1 completed before December 1, 2020 ~~2019~~. Upon completion, the
2 report on the study shall be filed with the Clerk of the House
3 of Representatives and the Secretary of the Senate in
4 electronic form only, in the manner that the Clerk and the
5 Secretary shall direct.

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

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

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

10 (30 ILCS 500/20-25.1 new)

11 Sec. 20-25.1. Special expedited procurement.

12 (a) The Chief Procurement Officer shall work with the
13 Department of Healthcare and Family Services to identify an
14 appropriate method of source selection that will result in an
15 executed contract for the technology required by Section
16 5-30.12 of the Illinois Public Aid Code no later than August 1,
17 2019 in order to target implementation of the technology to be
18 procured by January 1, 2020. The method of source selection may
19 be sole source, emergency, or other expedited process.

20 (b) Due to the negative impact on access to critical State
21 health care services and the ability to draw federal match for
22 services being reimbursed caused by issues with implementation
23 of the Integrated Eligibility System by the Department of Human
24 Services, the Department of Healthcare and Family Services, and

1 the Department of Innovation and Technology, the General
2 Assembly finds that a threat to public health exists and to
3 prevent or minimize serious disruption in critical State
4 services that affect health, an emergency purchase of a vendor
5 shall be made by the Department of Healthcare and Family
6 Services to assess the Integrated Eligibility System for
7 critical gaps and processing errors and to monitor the
8 performance of the Integrated Eligibility System vendor under
9 the terms of its contract. The emergency purchase shall not
10 exceed 2 years. Notwithstanding any other provision of this
11 Code, such emergency purchase shall extend without a hearing
12 required by Section 20-30 until the integrated eligibility
13 system is stabilized and performing according to the needs of
14 the State to ensure continued access to health care for
15 eligible individuals.

16 Section 15. The Illinois Banking Act is amended by changing
17 Section 48.1 as follows:

18 (205 ILCS 5/48.1) (from Ch. 17, par. 360)

19 Sec. 48.1. Customer financial records; confidentiality.

20 (a) For the purpose of this Section, the term "financial
21 records" means any original, any copy, or any summary of:

22 (1) a document granting signature authority over a
23 deposit or account;

24 (2) a statement, ledger card or other record on any

1 deposit or account, which shows each transaction in or with
2 respect to that account;

3 (3) a check, draft or money order drawn on a bank or
4 issued and payable by a bank; or

5 (4) any other item containing information pertaining
6 to any relationship established in the ordinary course of a
7 bank's business between a bank and its customer, including
8 financial statements or other financial information
9 provided by the customer.

10 (b) This Section does not prohibit:

11 (1) The preparation, examination, handling or
12 maintenance of any financial records by any officer,
13 employee or agent of a bank having custody of the records,
14 or the examination of the records by a certified public
15 accountant engaged by the bank to perform an independent
16 audit.

17 (2) The examination of any financial records by, or the
18 furnishing of financial records by a bank to, any officer,
19 employee or agent of (i) the Commissioner of Banks and Real
20 Estate, (ii) after May 31, 1997, a state regulatory
21 authority authorized to examine a branch of a State bank
22 located in another state, (iii) the Comptroller of the
23 Currency, (iv) the Federal Reserve Board, or (v) the
24 Federal Deposit Insurance Corporation for use solely in the
25 exercise of his duties as an officer, employee, or agent.

26 (3) The publication of data furnished from financial

1 records relating to customers where the data cannot be
2 identified to any particular customer or account.

3 (4) The making of reports or returns required under
4 Chapter 61 of the Internal Revenue Code of 1986.

5 (5) Furnishing information concerning the dishonor of
6 any negotiable instrument permitted to be disclosed under
7 the Uniform Commercial Code.

8 (6) The exchange in the regular course of business of
9 (i) credit information between a bank and other banks or
10 financial institutions or commercial enterprises, directly
11 or through a consumer reporting agency or (ii) financial
12 records or information derived from financial records
13 between a bank and other banks or financial institutions or
14 commercial enterprises for the purpose of conducting due
15 diligence pursuant to a purchase or sale involving the bank
16 or assets or liabilities of the bank.

17 (7) The furnishing of information to the appropriate
18 law enforcement authorities where the bank reasonably
19 believes it has been the victim of a crime.

20 (8) The furnishing of information under the Revised
21 Uniform Unclaimed Property Act.

22 (9) The furnishing of information under the Illinois
23 Income Tax Act and the Illinois Estate and
24 Generation-Skipping Transfer Tax Act.

25 (10) The furnishing of information under the federal
26 Currency and Foreign Transactions Reporting Act Title 31,

1 United States Code, Section 1051 et seq.

2 (11) The furnishing of information under any other
3 statute that by its terms or by regulations promulgated
4 thereunder requires the disclosure of financial records
5 other than by subpoena, summons, warrant, or court order.

6 (12) The furnishing of information about the existence
7 of an account of a person to a judgment creditor of that
8 person who has made a written request for that information.

9 (13) The exchange in the regular course of business of
10 information between commonly owned banks in connection
11 with a transaction authorized under paragraph (23) of
12 Section 5 and conducted at an affiliate facility.

13 (14) The furnishing of information in accordance with
14 the federal Personal Responsibility and Work Opportunity
15 Reconciliation Act of 1996. Any bank governed by this Act
16 shall enter into an agreement for data exchanges with a
17 State agency provided the State agency pays to the bank a
18 reasonable fee not to exceed its actual cost incurred. A
19 bank providing information in accordance with this item
20 shall not be liable to any account holder or other person
21 for any disclosure of information to a State agency, for
22 encumbering or surrendering any assets held by the bank in
23 response to a lien or order to withhold and deliver issued
24 by a State agency, or for any other action taken pursuant
25 to this item, including individual or mechanical errors,
26 provided the action does not constitute gross negligence or

1 willful misconduct. A bank shall have no obligation to
2 hold, encumber, or surrender assets until it has been
3 served with a subpoena, summons, warrant, court or
4 administrative order, lien, or levy.

5 (15) The exchange in the regular course of business of
6 information between a bank and any commonly owned affiliate
7 of the bank, subject to the provisions of the Financial
8 Institutions Insurance Sales Law.

9 (16) The furnishing of information to law enforcement
10 authorities, the Illinois Department on Aging and its
11 regional administrative and provider agencies, the
12 Department of Human Services Office of Inspector General,
13 or public guardians: (i) upon subpoena by the investigatory
14 entity or the guardian, or (ii) if there is suspicion by
15 the bank that a customer who is an elderly person or person
16 with a disability has been or may become the victim of
17 financial exploitation. For the purposes of this item (16),
18 the term: (i) "elderly person" means a person who is 60 or
19 more years of age, (ii) "disabled person" means a person
20 who has or reasonably appears to the bank to have a
21 physical or mental disability that impairs his or her
22 ability to seek or obtain protection from or prevent
23 financial exploitation, and (iii) "financial exploitation"
24 means tortious or illegal use of the assets or resources of
25 an elderly or disabled person, and includes, without
26 limitation, misappropriation of the elderly or disabled

1 person's assets or resources by undue influence, breach of
2 fiduciary relationship, intimidation, fraud, deception,
3 extortion, or the use of assets or resources in any manner
4 contrary to law. A bank or person furnishing information
5 pursuant to this item (16) shall be entitled to the same
6 rights and protections as a person furnishing information
7 under the Adult Protective Services Act and the Illinois
8 Domestic Violence Act of 1986.

9 (17) The disclosure of financial records or
10 information as necessary to effect, administer, or enforce
11 a transaction requested or authorized by the customer, or
12 in connection with:

13 (A) servicing or processing a financial product or
14 service requested or authorized by the customer;

15 (B) maintaining or servicing a customer's account
16 with the bank; or

17 (C) a proposed or actual securitization or
18 secondary market sale (including sales of servicing
19 rights) related to a transaction of a customer.

20 Nothing in this item (17), however, authorizes the sale
21 of the financial records or information of a customer
22 without the consent of the customer.

23 (18) The disclosure of financial records or
24 information as necessary to protect against actual or
25 potential fraud, unauthorized transactions, claims, or
26 other liability.

1 (19) ~~(A)(a)~~ The disclosure of financial records or
2 information related to a private label credit program
3 between a financial institution and a private label party
4 in connection with that private label credit program. Such
5 information is limited to outstanding balance, available
6 credit, payment and performance and account history,
7 product references, purchase information, and information
8 related to the identity of the customer.

9 (B)(1) For purposes of this paragraph (19) of
10 subsection (b) of Section 48.1, a "private label credit
11 program" means a credit program involving a financial
12 institution and a private label party that is used by a
13 customer of the financial institution and the private label
14 party primarily for payment for goods or services sold,
15 manufactured, or distributed by a private label party.

16 (2) For purposes of this paragraph (19) of subsection
17 (b) of Section 48.1, a "private label party" means, with
18 respect to a private label credit program, any of the
19 following: a retailer, a merchant, a manufacturer, a trade
20 group, or any such person's affiliate, subsidiary, member,
21 agent, or service provider.

22 (20) ~~(A)(a)~~ The furnishing of financial records of a
23 customer to the Department to aid the Department's initial
24 determination or subsequent re-determination of the
25 customer's eligibility for Medicaid and Medicaid long-term
26 care benefits for long-term care when requested by the

1 I, , hereby authorize
2 (Name of Customer)

3
4 (Name of Financial Institution)

5
6 (Address of Financial Institution)

7 to disclose the following financial records:

8 any and all information concerning my deposit, savings, money
9 market, certificate of deposit, individual retirement,
10 retirement plan, 401(k) plan, incentive plan, employee benefit
11 plan, mutual fund and loan accounts (including, but not limited
12 to, any indebtedness or obligation for which I am a
13 co-borrower, co-obligor, guarantor, or surety), and any and all
14 other accounts in which I have an interest and any other
15 information regarding me in the possession of the Financial
16 Institution,

17 to the Illinois Department of Human Services or the Illinois
18 Department of Healthcare and Family Services, or both ("the
19 Department"), for the following purpose(s):

20 to aid in the initial determination or re-determination by the

1 State of Illinois of my eligibility for Medicaid long-term care
2 benefits, pursuant to applicable law.

3 I understand that this Consent and Authorization may be revoked
4 by me in writing at any time before my financial records, as
5 described above, are disclosed, and that this Consent and
6 Authorization is valid until the Financial Institution
7 receives my written revocation. This Consent and Authorization
8 shall constitute valid authorization for the Department
9 identified above to inspect all such financial records set
10 forth above, and to request and receive copies of such
11 financial records from the Financial Institution ~~(subject to~~
12 ~~such records search and reproduction reimbursement policies as~~
13 ~~the Financial Institution may have in place)~~. An executed copy
14 of this Consent and Authorization shall be sufficient and as
15 good as the original and permission is hereby granted to honor
16 a photostatic or electronic copy of this Consent and
17 Authorization. Disclosure is strictly limited to the
18 Department identified above and no other person or entity shall
19 receive my financial records pursuant to this Consent and
20 Authorization. ~~By signing this form, I agree to indemnify and~~
21 ~~hold the Financial Institution harmless from any and all~~
22 ~~claims, demands, and losses, including reasonable attorneys~~
23 ~~fees and expenses, arising from or incurred in its reliance on~~
24 ~~this Consent and Authorization. As used herein, "Customer"~~
25 ~~shall mean "Member" if the Financial Institution is a credit~~

1 ~~union.~~

2

3 (Date) (Signature of Customer)

4

5

6 (Address of Customer)

7

8 (Customer's birth date)

9 (month/day/year)

10 ~~The undersigned witness certifies that,~~
11 ~~known to me to be the same person whose name is subscribed as~~
12 ~~the customer to the foregoing Consent and Authorization,~~
13 ~~appeared before me and the notary public and acknowledged~~
14 ~~signing and delivering the instrument as his or her free and~~
15 ~~voluntary act for the uses and purposes therein set forth. I~~
16 ~~believe him or her to be of sound mind and memory. The~~
17 ~~undersigned witness also certifies that the witness is not an~~
18 ~~owner, operator, or relative of an owner or operator of a~~
19 ~~long term care facility in which the customer is a patient or~~
20 ~~resident.~~

21 Dated:

1 ~~(Signature of Witness)~~

2

3 ~~(Print Name of Witness)~~

4

5

6 ~~(Address of Witness)~~

7 ~~State of Illinois)~~

8 ~~) ss.~~

9 ~~County of)~~

10 ~~The undersigned, a notary public in and for the above county~~
11 ~~and state, certifies that, known to me to be the~~
12 ~~same person whose name is subscribed as the customer to the~~
13 ~~foregoing Consent and Authorization, appeared before me~~
14 ~~together with the witness,, in person and~~
15 ~~acknowledged signing and delivering the instrument as the free~~
16 ~~and voluntary act of the customer for the uses and purposes~~
17 ~~therein set forth.~~

18 ~~Dated:~~

19 ~~Notary Public:~~

20 ~~My commission expires:~~

1 (C) ~~(b)~~ In no event shall the bank distribute the
2 customer's financial records to the long-term care
3 facility from which the customer seeks initial or
4 continuing residency or long-term care services.

5 (D) ~~(e)~~ A bank providing financial records of a
6 customer in good faith relying on a consent and
7 authorization executed and tendered in accordance with
8 this paragraph (20) shall not be liable to the customer or
9 any other person in relation to the bank's disclosure of
10 the customer's financial records to the Department. ~~The~~
11 ~~customer signing the consent and authorization shall~~
12 ~~indemnify and hold the bank harmless that relies in good~~
13 ~~faith upon the consent and authorization and incurs a loss~~
14 ~~because of such reliance. The bank recovering under this~~
15 ~~indemnification provision shall also be entitled to~~
16 ~~reasonable attorney's fees and the expenses of recovery.~~

17 (E) ~~(d)~~ ~~A bank shall be reimbursed by the customer for~~
18 ~~all costs reasonably necessary and directly incurred in~~
19 ~~searching for, reproducing, and disclosing a customer's~~
20 ~~financial records required or requested to be produced~~
21 ~~pursuant to any consent and authorization executed under~~
22 ~~this paragraph (20).~~ The requested financial records shall
23 be delivered to the Department within 10 days after
24 receiving a properly executed consent and authorization or
25 at the earliest practicable time thereafter if the
26 requested records cannot be delivered within 10 days, ~~7~~ but

1 ~~delivery may be delayed until the final reimbursement of~~
2 ~~all costs is received by the bank. The bank may honor a~~
3 ~~photostatic or electronic copy of a properly executed~~
4 ~~consent and authorization. Notwithstanding any other~~
5 ~~provision of law, the delays of a customer, bank, or~~
6 ~~long-term care facility in providing required information~~
7 ~~or supporting documentation for the long-term care service~~
8 ~~authorization process shall not be attributable to the~~
9 ~~Department when evaluating the Department's compliance~~
10 ~~with Medicaid timeliness standards.~~

11 (F) ~~(e)~~ Nothing in this paragraph (20) shall impair,
12 abridge, or abrogate the right of a customer to:

13 (1) directly disclose his or her financial records
14 to the Department or any other person; or

15 (2) authorize his or her attorney or duly appointed
16 agent to request and obtain the customer's financial
17 records and disclose those financial records to the
18 Department.

19 (G) ~~(f)~~ For purposes of this paragraph (20),
20 "Department" means the Department of Human Services and the
21 Department of Healthcare and Family Services or any
22 successor administrative agency of either agency. Nothing
23 in this paragraph (20) is intended to impair the
24 Department's ability to operate an asset verification
25 system in accordance with 42 U.S.C. 1396w, provided the
26 customer's authorization is obtained by the Department.

1 ~~(b) (1) For purposes of this paragraph (19) of~~
2 ~~subsection (b) of Section 48.1, a "private label credit~~
3 ~~program" means a credit program involving a financial~~
4 ~~institution and a private label party that is used by a~~
5 ~~customer of the financial institution and the private label~~
6 ~~party primarily for payment for goods or services sold,~~
7 ~~manufactured, or distributed by a private label party.~~

8 ~~(2) For purposes of this paragraph (19) of subsection~~
9 ~~(b) of Section 48.1, a "private label party" means, with~~
10 ~~respect to a private label credit program, any of the~~
11 ~~following: a retailer, a merchant, a manufacturer, a trade~~
12 ~~group, or any such person's affiliate, subsidiary, member,~~
13 ~~agent, or service provider.~~

14 (c) Except as otherwise provided by this Act, a bank may
15 not disclose to any person, except to the customer or his duly
16 authorized agent, any financial records or financial
17 information obtained from financial records relating to that
18 customer of that bank unless:

19 (1) the customer has authorized disclosure to the
20 person;

21 (2) the financial records are disclosed in response to
22 a lawful subpoena, summons, warrant, citation to discover
23 assets, or court order which meets the requirements of
24 subsection (d) of this Section; or

25 (3) the bank is attempting to collect an obligation
26 owed to the bank and the bank complies with the provisions

1 of Section 2I of the Consumer Fraud and Deceptive Business
2 Practices Act.

3 (d) A bank shall disclose financial records under paragraph
4 (2) of subsection (c) of this Section under a lawful subpoena,
5 summons, warrant, citation to discover assets, or court order
6 only after the bank mails a copy of the subpoena, summons,
7 warrant, citation to discover assets, or court order to the
8 person establishing the relationship with the bank, if living,
9 and, otherwise his personal representative, if known, at his
10 last known address by first class mail, postage prepaid, unless
11 the bank is specifically prohibited from notifying the person
12 by order of court or by applicable State or federal law. A bank
13 shall not mail a copy of a subpoena to any person pursuant to
14 this subsection if the subpoena was issued by a grand jury
15 under the Statewide Grand Jury Act.

16 (e) Any officer or employee of a bank who knowingly and
17 willfully furnishes financial records in violation of this
18 Section is guilty of a business offense and, upon conviction,
19 shall be fined not more than \$1,000.

20 (f) Any person who knowingly and willfully induces or
21 attempts to induce any officer or employee of a bank to
22 disclose financial records in violation of this Section is
23 guilty of a business offense and, upon conviction, shall be
24 fined not more than \$1,000.

25 (g) A bank shall be reimbursed for costs that are
26 reasonably necessary and that have been directly incurred in

1 searching for, reproducing, or transporting books, papers,
2 records, or other data required or requested to be produced
3 pursuant to a lawful subpoena, summons, warrant, citation to
4 discover assets, or court order. The Commissioner shall
5 determine the rates and conditions under which payment may be
6 made.

7 (Source: P.A. 99-143, eff. 7-27-15; 100-22, eff. 1-1-18;
8 100-664, eff. 1-1-19; 100-888, eff. 8-14-18; revised
9 10-22-18.)

10 Section 20. The Savings Bank Act is amended by changing
11 Section 4013 as follows:

12 (205 ILCS 205/4013) (from Ch. 17, par. 7304-13)

13 Sec. 4013. Access to books and records; communication with
14 members and shareholders.

15 (a) Every member or shareholder shall have the right to
16 inspect books and records of the savings bank that pertain to
17 his accounts. Otherwise, the right of inspection and
18 examination of the books and records shall be limited as
19 provided in this Act, and no other person shall have access to
20 the books and records nor shall be entitled to a list of the
21 members or shareholders.

22 (b) For the purpose of this Section, the term "financial
23 records" means any original, any copy, or any summary of (1) a
24 document granting signature authority over a deposit or

1 account; (2) a statement, ledger card, or other record on any
2 deposit or account that shows each transaction in or with
3 respect to that account; (3) a check, draft, or money order
4 drawn on a savings bank or issued and payable by a savings
5 bank; or (4) any other item containing information pertaining
6 to any relationship established in the ordinary course of a
7 savings bank's business between a savings bank and its
8 customer, including financial statements or other financial
9 information provided by the member or shareholder.

10 (c) This Section does not prohibit:

11 (1) The preparation, examination, handling, or
12 maintenance of any financial records by any officer,
13 employee, or agent of a savings bank having custody of
14 records or examination of records by a certified public
15 accountant engaged by the savings bank to perform an
16 independent audit.

17 (2) The examination of any financial records by, or the
18 furnishing of financial records by a savings bank to, any
19 officer, employee, or agent of the Commissioner of Banks
20 and Real Estate or the federal depository institution
21 regulator for use solely in the exercise of his duties as
22 an officer, employee, or agent.

23 (3) The publication of data furnished from financial
24 records relating to members or holders of capital where the
25 data cannot be identified to any particular member,
26 shareholder, or account.

1 (4) The making of reports or returns required under
2 Chapter 61 of the Internal Revenue Code of 1986.

3 (5) Furnishing information concerning the dishonor of
4 any negotiable instrument permitted to be disclosed under
5 the Uniform Commercial Code.

6 (6) The exchange in the regular course of business of
7 (i) credit information between a savings bank and other
8 savings banks or financial institutions or commercial
9 enterprises, directly or through a consumer reporting
10 agency or (ii) financial records or information derived
11 from financial records between a savings bank and other
12 savings banks or financial institutions or commercial
13 enterprises for the purpose of conducting due diligence
14 pursuant to a purchase or sale involving the savings bank
15 or assets or liabilities of the savings bank.

16 (7) The furnishing of information to the appropriate
17 law enforcement authorities where the savings bank
18 reasonably believes it has been the victim of a crime.

19 (8) The furnishing of information pursuant to the
20 Revised Uniform Unclaimed Property Act.

21 (9) The furnishing of information pursuant to the
22 Illinois Income Tax Act and the Illinois Estate and
23 Generation-Skipping Transfer Tax Act.

24 (10) The furnishing of information pursuant to the
25 federal Currency and Foreign Transactions Reporting Act,
26 (Title 31, United States Code, Section 1051 et seq.).

1 (11) The furnishing of information pursuant to any
2 other statute which by its terms or by regulations
3 promulgated thereunder requires the disclosure of
4 financial records other than by subpoena, summons,
5 warrant, or court order.

6 (12) The furnishing of information in accordance with
7 the federal Personal Responsibility and Work Opportunity
8 Reconciliation Act of 1996. Any savings bank governed by
9 this Act shall enter into an agreement for data exchanges
10 with a State agency provided the State agency pays to the
11 savings bank a reasonable fee not to exceed its actual cost
12 incurred. A savings bank providing information in
13 accordance with this item shall not be liable to any
14 account holder or other person for any disclosure of
15 information to a State agency, for encumbering or
16 surrendering any assets held by the savings bank in
17 response to a lien or order to withhold and deliver issued
18 by a State agency, or for any other action taken pursuant
19 to this item, including individual or mechanical errors,
20 provided the action does not constitute gross negligence or
21 willful misconduct. A savings bank shall have no obligation
22 to hold, encumber, or surrender assets until it has been
23 served with a subpoena, summons, warrant, court or
24 administrative order, lien, or levy.

25 (13) The furnishing of information to law enforcement
26 authorities, the Illinois Department on Aging and its

1 regional administrative and provider agencies, the
2 Department of Human Services Office of Inspector General,
3 or public guardians: (i) upon subpoena by the investigatory
4 entity or the guardian, or (ii) if there is suspicion by
5 the savings bank that a customer who is an elderly person
6 or person with a disability has been or may become the
7 victim of financial exploitation. For the purposes of this
8 item (13), the term: (i) "elderly person" means a person
9 who is 60 or more years of age, (ii) "person with a
10 disability" means a person who has or reasonably appears to
11 the savings bank to have a physical or mental disability
12 that impairs his or her ability to seek or obtain
13 protection from or prevent financial exploitation, and
14 (iii) "financial exploitation" means tortious or illegal
15 use of the assets or resources of an elderly person or
16 person with a disability, and includes, without
17 limitation, misappropriation of the assets or resources of
18 the elderly person or person with a disability by undue
19 influence, breach of fiduciary relationship, intimidation,
20 fraud, deception, extortion, or the use of assets or
21 resources in any manner contrary to law. A savings bank or
22 person furnishing information pursuant to this item (13)
23 shall be entitled to the same rights and protections as a
24 person furnishing information under the Adult Protective
25 Services Act and the Illinois Domestic Violence Act of
26 1986.

1 (14) The disclosure of financial records or
2 information as necessary to effect, administer, or enforce
3 a transaction requested or authorized by the member or
4 holder of capital, or in connection with:

5 (A) servicing or processing a financial product or
6 service requested or authorized by the member or holder
7 of capital;

8 (B) maintaining or servicing an account of a member
9 or holder of capital with the savings bank; or

10 (C) a proposed or actual securitization or
11 secondary market sale (including sales of servicing
12 rights) related to a transaction of a member or holder
13 of capital.

14 Nothing in this item (14), however, authorizes the sale
15 of the financial records or information of a member or
16 holder of capital without the consent of the member or
17 holder of capital.

18 (15) The exchange in the regular course of business of
19 information between a savings bank and any commonly owned
20 affiliate of the savings bank, subject to the provisions of
21 the Financial Institutions Insurance Sales Law.

22 (16) The disclosure of financial records or
23 information as necessary to protect against or prevent
24 actual or potential fraud, unauthorized transactions,
25 claims, or other liability.

26 (17) (a) The disclosure of financial records or

1 information related to a private label credit program
2 between a financial institution and a private label party
3 in connection with that private label credit program. Such
4 information is limited to outstanding balance, available
5 credit, payment and performance and account history,
6 product references, purchase information, and information
7 related to the identity of the customer.

8 (b) (1) For purposes of this paragraph (17) of
9 subsection (c) of Section 4013, a "private label credit
10 program" means a credit program involving a financial
11 institution and a private label party that is used by a
12 customer of the financial institution and the private label
13 party primarily for payment for goods or services sold,
14 manufactured, or distributed by a private label party.

15 (2) For purposes of this paragraph (17) of subsection
16 (c) of Section 4013, a "private label party" means, with
17 respect to a private label credit program, any of the
18 following: a retailer, a merchant, a manufacturer, a trade
19 group, or any such person's affiliate, subsidiary, member,
20 agent, or service provider.

21 (18) (a) The furnishing of financial records of a
22 customer to the Department to aid the Department's initial
23 determination or subsequent re-determination of the
24 customer's eligibility for Medicaid and Medicaid long-term
25 care benefits for long-term care services when requested by
26 the Department, provided that the Department receives an

1 authorization of the customer and maintains the
2 authorization in accordance with the requirements of 42
3 U.S.C. 1396w.

4 (b) The furnishing of financial records of a customer
5 to the Department to aid the Department's initial
6 determination or subsequent re-determination of the
7 customer's eligibility for Medicaid and Medicaid long-term
8 care benefits for long-term care services when requested by
9 someone other than the customer or the Department, provided
10 that the savings bank receives the written consent and
11 authorization of the customer, which shall:

12 ~~(1) have the customer's signature notarized;~~
13 ~~(2) be signed by at least one witness who certifies~~
14 ~~that he or she believes the customer to be of sound~~
15 ~~mind and memory;~~

16 (1) ~~(3)~~ be tendered to the savings bank at the
17 earliest practicable time following its execution~~;~~
18 ~~certification, and notarization;~~

19 (2) ~~(4)~~ specifically limit the disclosure of the
20 customer's financial records to the Department; and

21 (3) ~~(5)~~ be in substantially the following form:

22 CUSTOMER CONSENT AND AUTHORIZATION
23 FOR RELEASE OF FINANCIAL RECORDS

24 I, , hereby authorize

1 (Name of Customer)

2

3 (Name of Financial Institution)

4

5 (Address of Financial Institution)

6 to disclose the following financial records:

7 any and all information concerning my deposit, savings, money
8 market, certificate of deposit, individual retirement,
9 retirement plan, 401(k) plan, incentive plan, employee benefit
10 plan, mutual fund and loan accounts (including, but not limited
11 to, any indebtedness or obligation for which I am a
12 co-borrower, co-obligor, guarantor, or surety), and any and all
13 other accounts in which I have an interest and any other
14 information regarding me in the possession of the Financial
15 Institution,

16 to the Illinois Department of Human Services or the Illinois
17 Department of Healthcare and Family Services, or both ("the
18 Department"), for the following purpose(s):

19 to aid in the initial determination or re-determination by the
20 State of Illinois of my eligibility for Medicaid long-term care

1 benefits, pursuant to applicable law.

2 I understand that this Consent and Authorization may be revoked
3 by me in writing at any time before my financial records, as
4 described above, are disclosed, and that this Consent and
5 Authorization is valid until the Financial Institution
6 receives my written revocation. This Consent and Authorization
7 shall constitute valid authorization for the Department
8 identified above to inspect all such financial records set
9 forth above, and to request and receive copies of such
10 financial records from the Financial Institution ~~(subject to~~
11 ~~such records search and reproduction reimbursement policies as~~
12 ~~the Financial Institution may have in place)~~. An executed copy
13 of this Consent and Authorization shall be sufficient and as
14 good as the original and permission is hereby granted to honor
15 a photostatic or electronic copy of this Consent and
16 Authorization. Disclosure is strictly limited to the
17 Department identified above and no other person or entity shall
18 receive my financial records pursuant to this Consent and
19 Authorization. ~~By signing this form, I agree to indemnify and~~
20 ~~hold the Financial Institution harmless from any and all~~
21 ~~claims, demands, and losses, including reasonable attorneys~~
22 ~~fees and expenses, arising from or incurred in its reliance on~~
23 ~~this Consent and Authorization. As used herein, "Customer"~~
24 ~~shall mean "Member" if the Financial Institution is a credit~~
25 ~~union.~~

1
2

(Date) (Signature of Customer)

3
4

(Address of Customer)

6
7

(Customer's birth date)

8 (month/day/year)

9 ~~The undersigned witness certifies that,~~
10 ~~known to me to be the same person whose name is subscribed as~~
11 ~~the customer to the foregoing Consent and Authorization,~~
12 ~~appeared before me and the notary public and acknowledged~~
13 ~~signing and delivering the instrument as his or her free and~~
14 ~~voluntary act for the uses and purposes therein set forth. I~~
15 ~~believe him or her to be of sound mind and memory. The~~
16 ~~undersigned witness also certifies that the witness is not an~~
17 ~~owner, operator, or relative of an owner or operator of a~~
18 ~~long term care facility in which the customer is a patient or~~
19 ~~resident.~~

20 Dated:

21 ~~(Signature of Witness)~~

1 the customer's financial records to the long-term care
2 facility from which the customer seeks initial or
3 continuing residency or long-term care services.

4 (d) ~~(e)~~ A savings bank providing financial records of a
5 customer in good faith relying on a consent and
6 authorization executed and tendered in accordance with
7 this paragraph (18) shall not be liable to the customer or
8 any other person in relation to the savings bank's
9 disclosure of the customer's financial records to the
10 Department. ~~The customer signing the consent and~~
11 ~~authorization shall indemnify and hold the savings bank~~
12 ~~harmless that relies in good faith upon the consent and~~
13 ~~authorization and incurs a loss because of such reliance.~~
14 ~~The savings bank recovering under this indemnification~~
15 ~~provision shall also be entitled to reasonable attorney's~~
16 ~~fees and the expenses of recovery.~~

17 (e) ~~(d)~~ ~~A savings bank shall be reimbursed by the~~
18 ~~customer for all costs reasonably necessary and directly~~
19 ~~incurred in searching for, reproducing, and disclosing a~~
20 ~~customer's financial records required or requested to be~~
21 ~~produced pursuant to any consent and authorization~~
22 ~~executed under this paragraph (18).~~ The requested
23 financial records shall be delivered to the Department
24 within 10 days after receiving a properly executed consent
25 and authorization or at the earliest practicable time
26 thereafter if the requested records cannot be delivered

1 within 10 days. ~~, but delivery may be delayed until the~~
2 ~~final reimbursement of all costs is received by the savings~~
3 ~~bank.~~ The savings bank may honor a photostatic or
4 electronic copy of a properly executed consent and
5 authorization. Notwithstanding any other provision of law,
6 the delays of a customer, bank, or long-term care facility
7 in providing required information or supporting
8 documentation for the long-term care service authorization
9 process shall not be attributable to the Department when
10 evaluating the Department's compliance with Medicaid
11 timeliness standards.

12 (f) ~~(e)~~ Nothing in this paragraph (18) shall impair,
13 abridge, or abrogate the right of a customer to:

14 (1) directly disclose his or her financial records
15 to the Department or any other person; or

16 (2) authorize his or her attorney or duly appointed
17 agent to request and obtain the customer's financial
18 records and disclose those financial records to the
19 Department.

20 (g) ~~(f)~~ For purposes of this paragraph (18),
21 "Department" means the Department of Human Services and the
22 Department of Healthcare and Family Services or any
23 successor administrative agency of either agency. Nothing
24 in this paragraph (18) is intended to impair the
25 Department's ability to operate an asset verification
26 system in accordance with 42 U.S.C. 1396w, provided the

1 customer's authorization is obtained by the Department.

2 (d) A savings bank may not disclose to any person, except
3 to the member or holder of capital or his duly authorized
4 agent, any financial records relating to that member or
5 shareholder of the savings bank unless:

6 (1) the member or shareholder has authorized
7 disclosure to the person; or

8 (2) the financial records are disclosed in response to
9 a lawful subpoena, summons, warrant, citation to discover
10 assets, or court order that meets the requirements of
11 subsection (e) of this Section.

12 (e) A savings bank shall disclose financial records under
13 subsection (d) of this Section pursuant to a lawful subpoena,
14 summons, warrant, citation to discover assets, or court order
15 only after the savings bank mails a copy of the subpoena,
16 summons, warrant, citation to discover assets, or court order
17 to the person establishing the relationship with the savings
18 bank, if living, and otherwise, his personal representative, if
19 known, at his last known address by first class mail, postage
20 prepaid, unless the savings bank is specifically prohibited
21 from notifying the person by order of court.

22 (f) Any officer or employee of a savings bank who knowingly
23 and willfully furnishes financial records in violation of this
24 Section is guilty of a business offense and, upon conviction,
25 shall be fined not more than \$1,000.

26 (g) Any person who knowingly and willfully induces or

1 attempts to induce any officer or employee of a savings bank to
2 disclose financial records in violation of this Section is
3 guilty of a business offense and, upon conviction, shall be
4 fined not more than \$1,000.

5 (h) If any member or shareholder desires to communicate
6 with the other members or shareholders of the savings bank with
7 reference to any question pending or to be presented at an
8 annual or special meeting, the savings bank shall give that
9 person, upon request, a statement of the approximate number of
10 members or shareholders entitled to vote at the meeting and an
11 estimate of the cost of preparing and mailing the
12 communication. The requesting member shall submit the
13 communication to the Commissioner who, upon finding it to be
14 appropriate and truthful, shall direct that it be prepared and
15 mailed to the members upon the requesting member's or
16 shareholder's payment or adequate provision for payment of the
17 expenses of preparation and mailing.

18 (i) A savings bank shall be reimbursed for costs that are
19 necessary and that have been directly incurred in searching
20 for, reproducing, or transporting books, papers, records, or
21 other data of a customer required to be reproduced pursuant to
22 a lawful subpoena, warrant, citation to discover assets, or
23 court order.

24 (j) Notwithstanding the provisions of this Section, a
25 savings bank may sell or otherwise make use of lists of
26 customers' names and addresses. All other information

1 regarding a customer's account is subject to the disclosure
2 provisions of this Section. At the request of any customer,
3 that customer's name and address shall be deleted from any list
4 that is to be sold or used in any other manner beyond
5 identification of the customer's accounts.

6 (Source: P.A. 99-143, eff. 7-27-15; 100-22, eff. 1-1-18;
7 100-201, eff. 8-18-17; 100-664, eff. 1-1-19.)

8 Section 25. The Illinois Credit Union Act is amended by
9 changing Section 10 as follows:

10 (205 ILCS 305/10) (from Ch. 17, par. 4411)

11 Sec. 10. Credit union records; member financial records.

12 (1) A credit union shall establish and maintain books,
13 records, accounting systems and procedures which accurately
14 reflect its operations and which enable the Department to
15 readily ascertain the true financial condition of the credit
16 union and whether it is complying with this Act.

17 (2) A photostatic or photographic reproduction of any
18 credit union records shall be admissible as evidence of
19 transactions with the credit union.

20 (3) (a) For the purpose of this Section, the term "financial
21 records" means any original, any copy, or any summary of (1) a
22 document granting signature authority over an account, (2) a
23 statement, ledger card or other record on any account which
24 shows each transaction in or with respect to that account, (3)

1 a check, draft or money order drawn on a financial institution
2 or other entity or issued and payable by or through a financial
3 institution or other entity, or (4) any other item containing
4 information pertaining to any relationship established in the
5 ordinary course of business between a credit union and its
6 member, including financial statements or other financial
7 information provided by the member.

8 (b) This Section does not prohibit:

9 (1) The preparation, examination, handling or
10 maintenance of any financial records by any officer,
11 employee or agent of a credit union having custody of such
12 records, or the examination of such records by a certified
13 public accountant engaged by the credit union to perform an
14 independent audit.

15 (2) The examination of any financial records by or the
16 furnishing of financial records by a credit union to any
17 officer, employee or agent of the Department, the National
18 Credit Union Administration, Federal Reserve board or any
19 insurer of share accounts for use solely in the exercise of
20 his duties as an officer, employee or agent.

21 (3) The publication of data furnished from financial
22 records relating to members where the data cannot be
23 identified to any particular customer of account.

24 (4) The making of reports or returns required under
25 Chapter 61 of the Internal Revenue Code of 1954.

26 (5) Furnishing information concerning the dishonor of

1 any negotiable instrument permitted to be disclosed under
2 the Uniform Commercial Code.

3 (6) The exchange in the regular course of business of
4 (i) credit information between a credit union and other
5 credit unions or financial institutions or commercial
6 enterprises, directly or through a consumer reporting
7 agency or (ii) financial records or information derived
8 from financial records between a credit union and other
9 credit unions or financial institutions or commercial
10 enterprises for the purpose of conducting due diligence
11 pursuant to a merger or a purchase or sale of assets or
12 liabilities of the credit union.

13 (7) The furnishing of information to the appropriate
14 law enforcement authorities where the credit union
15 reasonably believes it has been the victim of a crime.

16 (8) The furnishing of information pursuant to the
17 Revised Uniform Unclaimed Property Act.

18 (9) The furnishing of information pursuant to the
19 Illinois Income Tax Act and the Illinois Estate and
20 Generation-Skipping Transfer Tax Act.

21 (10) The furnishing of information pursuant to the
22 federal "Currency and Foreign Transactions Reporting Act",
23 Title 31, United States Code, Section 1051 et sequentia.

24 (11) The furnishing of information pursuant to any
25 other statute which by its terms or by regulations
26 promulgated thereunder requires the disclosure of

1 financial records other than by subpoena, summons, warrant
2 or court order.

3 (12) The furnishing of information in accordance with
4 the federal Personal Responsibility and Work Opportunity
5 Reconciliation Act of 1996. Any credit union governed by
6 this Act shall enter into an agreement for data exchanges
7 with a State agency provided the State agency pays to the
8 credit union a reasonable fee not to exceed its actual cost
9 incurred. A credit union providing information in
10 accordance with this item shall not be liable to any
11 account holder or other person for any disclosure of
12 information to a State agency, for encumbering or
13 surrendering any assets held by the credit union in
14 response to a lien or order to withhold and deliver issued
15 by a State agency, or for any other action taken pursuant
16 to this item, including individual or mechanical errors,
17 provided the action does not constitute gross negligence or
18 willful misconduct. A credit union shall have no obligation
19 to hold, encumber, or surrender assets until it has been
20 served with a subpoena, summons, warrant, court or
21 administrative order, lien, or levy.

22 (13) The furnishing of information to law enforcement
23 authorities, the Illinois Department on Aging and its
24 regional administrative and provider agencies, the
25 Department of Human Services Office of Inspector General,
26 or public guardians: (i) upon subpoena by the investigatory

1 entity or the guardian, or (ii) if there is suspicion by
2 the credit union that a member who is an elderly person or
3 person with a disability has been or may become the victim
4 of financial exploitation. For the purposes of this item
5 (13), the term: (i) "elderly person" means a person who is
6 60 or more years of age, (ii) "person with a disability"
7 means a person who has or reasonably appears to the credit
8 union to have a physical or mental disability that impairs
9 his or her ability to seek or obtain protection from or
10 prevent financial exploitation, and (iii) "financial
11 exploitation" means tortious or illegal use of the assets
12 or resources of an elderly person or person with a
13 disability, and includes, without limitation,
14 misappropriation of the elderly or disabled person's
15 assets or resources by undue influence, breach of fiduciary
16 relationship, intimidation, fraud, deception, extortion,
17 or the use of assets or resources in any manner contrary to
18 law. A credit union or person furnishing information
19 pursuant to this item (13) shall be entitled to the same
20 rights and protections as a person furnishing information
21 under the Adult Protective Services Act and the Illinois
22 Domestic Violence Act of 1986.

23 (14) The disclosure of financial records or
24 information as necessary to effect, administer, or enforce
25 a transaction requested or authorized by the member, or in
26 connection with:

1 (A) servicing or processing a financial product or
2 service requested or authorized by the member;

3 (B) maintaining or servicing a member's account
4 with the credit union; or

5 (C) a proposed or actual securitization or
6 secondary market sale (including sales of servicing
7 rights) related to a transaction of a member.

8 Nothing in this item (14), however, authorizes the sale
9 of the financial records or information of a member without
10 the consent of the member.

11 (15) The disclosure of financial records or
12 information as necessary to protect against or prevent
13 actual or potential fraud, unauthorized transactions,
14 claims, or other liability.

15 (16)(a) The disclosure of financial records or
16 information related to a private label credit program
17 between a financial institution and a private label party
18 in connection with that private label credit program. Such
19 information is limited to outstanding balance, available
20 credit, payment and performance and account history,
21 product references, purchase information, and information
22 related to the identity of the customer.

23 (b) (1) For purposes of this ~~item paragraph~~ (16) ~~of~~
24 ~~subsection (b) of Section 10,~~ a "private label credit
25 program" means a credit program involving a financial
26 institution and a private label party that is used by a

1 customer of the financial institution and the private label
2 party primarily for payment for goods or services sold,
3 manufactured, or distributed by a private label party.

4 (2) For purposes of this ~~item paragraph~~ (16) ~~of~~
5 ~~subsection (b) of Section 10, a~~ "private label party"
6 means, with respect to a private label credit program, any
7 of the following: a retailer, a merchant, a manufacturer, a
8 trade group, or any such person's affiliate, subsidiary,
9 member, agent, or service provider.

10 (17) (a) The furnishing of financial records of a member
11 to the Department to aid the Department's initial
12 determination or subsequent re-determination of the
13 member's eligibility for Medicaid and Medicaid long-term
14 care benefits for long-term care services when requested by
15 the Department, provided that the Department receives an
16 authorization of the customer and maintains the
17 authorization in accordance with the requirements of 42
18 U.S.C. 1396w.

19 (b) The furnishing of financial records of a customer
20 to the Department to aid the Department's initial
21 determination or subsequent re-determination of the
22 customer's eligibility for Medicaid and Medicaid long-term
23 care benefits for long-term care services when requested by
24 someone other than the customer or the Department, provided
25 that the credit union receives the written consent and
26 authorization of the member, which shall:

1 ~~(1) have the member's signature notarized;~~
 2 ~~(2) be signed by at least one witness who certifies~~
 3 ~~that he or she believes the member to be of sound mind~~
 4 ~~and memory;~~

5 (1) ~~(3)~~ be tendered to the credit union at the
 6 earliest practicable time following its execution,
 7 ~~certification, and notarization;~~

8 (2) ~~(4)~~ specifically limit the disclosure of the
 9 member's financial records to the Department; and

10 (3) ~~(5)~~ be in substantially the following form:

11 CUSTOMER CONSENT AND AUTHORIZATION
 12 FOR RELEASE OF FINANCIAL RECORDS

13 I, , hereby authorize
 14 (Name of Customer)

15
 16 (Name of Financial Institution)

17
 18 (Address of Financial Institution)

19 to disclose the following financial records:

20 any and all information concerning my deposit, savings, money

1 market, certificate of deposit, individual retirement,
2 retirement plan, 401(k) plan, incentive plan, employee benefit
3 plan, mutual fund and loan accounts (including, but not limited
4 to, any indebtedness or obligation for which I am a
5 co-borrower, co-obligor, guarantor, or surety), and any and all
6 other accounts in which I have an interest and any other
7 information regarding me in the possession of the Financial
8 Institution,

9 to the Illinois Department of Human Services or the Illinois
10 Department of Healthcare and Family Services, or both ("the
11 Department"), for the following purpose(s):

12 to aid in the initial determination or re-determination by the
13 State of Illinois of my eligibility for Medicaid long-term care
14 benefits, pursuant to applicable law.

15 I understand that this Consent and Authorization may be revoked
16 by me in writing at any time before my financial records, as
17 described above, are disclosed, and that this Consent and
18 Authorization is valid until the Financial Institution
19 receives my written revocation. This Consent and Authorization
20 shall constitute valid authorization for the Department
21 identified above to inspect all such financial records set
22 forth above, and to request and receive copies of such
23 financial records from the Financial Institution ~~(subject to~~

1 ~~such records search and reproduction reimbursement policies as~~
2 ~~the Financial Institution may have in place).~~ An executed copy
3 of this Consent and Authorization shall be sufficient and as
4 good as the original and permission is hereby granted to honor
5 a photostatic or electronic copy of this Consent and
6 Authorization. Disclosure is strictly limited to the
7 Department identified above and no other person or entity shall
8 receive my financial records pursuant to this Consent and
9 Authorization. ~~By signing this form, I agree to indemnify and~~
10 ~~hold the Financial Institution harmless from any and all~~
11 ~~claims, demands, and losses, including reasonable attorneys~~
12 ~~fees and expenses, arising from or incurred in its reliance on~~
13 ~~this Consent and Authorization. As used herein, "Customer"~~
14 ~~shall mean "Member" if the Financial Institution is a credit~~
15 ~~union.~~

16
17

(Date)

(Signature of Customer)

18
19

19
20

(Address of Customer)

21
22

(Customer's birth date)

23
(month/day/year)

1 ~~The undersigned witness certifies that,~~
 2 ~~known to me to be the same person whose name is subscribed as~~
 3 ~~the customer to the foregoing Consent and Authorization,~~
 4 ~~appeared before me and the notary public and acknowledged~~
 5 ~~signing and delivering the instrument as his or her free and~~
 6 ~~voluntary act for the uses and purposes therein set forth. I~~
 7 ~~believe him or her to be of sound mind and memory. The~~
 8 ~~undersigned witness also certifies that the witness is not an~~
 9 ~~owner, operator, or relative of an owner or operator of a~~
 10 ~~long term care facility in which the customer is a patient or~~
 11 ~~resident.~~

12 Dated:

13 ~~(Signature of Witness)~~

14

15 ~~(Print Name of Witness)~~

16

17

18 ~~(Address of Witness)~~

19 ~~State of Illinois)~~

20 ~~) ss.~~

21 ~~County of)~~

1 ~~The undersigned, a notary public in and for the above county~~
 2 ~~and state, certifies that, known to me to be the~~
 3 ~~same person whose name is subscribed as the customer to the~~
 4 ~~foregoing Consent and Authorization, appeared before me~~
 5 ~~together with the witness,, in person and~~
 6 ~~acknowledged signing and delivering the instrument as the free~~
 7 ~~and voluntary act of the customer for the uses and purposes~~
 8 ~~therein set forth.~~

9 Dated:

10 Notary Public:

11 My commission expires:

12 (c) ~~(b)~~ In no event shall the credit union distribute
 13 the member's financial records to the long-term care
 14 facility from which the member seeks initial or continuing
 15 residency or long-term care services.

16 (d) ~~(e)~~ A credit union providing financial records of a
 17 member in good faith relying on a consent and authorization
 18 executed and tendered in accordance with this item
 19 ~~subparagraph~~ (17) shall not be liable to the member or any
 20 other person in relation to the credit union's disclosure
 21 of the member's financial records to the Department. ~~The~~
 22 ~~member signing the consent and authorization shall~~
 23 ~~indemnify and hold the credit union harmless that relies in~~

1 ~~good faith upon the consent and authorization and incurs a~~
2 ~~loss because of such reliance. The credit union recovering~~
3 ~~under this indemnification provision shall also be~~
4 ~~entitled to reasonable attorney's fees and the expenses of~~
5 ~~recovery.~~

6 (e) ~~(d)~~ A credit union shall be reimbursed by the
7 member for all costs reasonably necessary and directly
8 incurred in searching for, reproducing, and disclosing a
9 member's financial records required or requested to be
10 produced pursuant to any consent and authorization
11 executed under this subparagraph ~~(17)~~. The requested
12 financial records shall be delivered to the Department
13 within 10 days after receiving a properly executed consent
14 and authorization or at the earliest practicable time
15 thereafter if the requested records cannot be delivered
16 within 10 days. ~~, but delivery may be delayed until the~~
17 ~~final reimbursement of all costs is received by the credit~~
18 ~~union.~~ The credit union may honor a photostatic or
19 electronic copy of a properly executed consent and
20 authorization. Notwithstanding any other provision of law,
21 the delays of a customer, bank or long-term care facility
22 in providing required information or supporting
23 documentation for the long-term care service authorization
24 process shall not be attributable to the Department when
25 evaluating the Department's compliance with Medicaid
26 timeliness standards.

1 (f) ~~(e)~~ Nothing in this item ~~subparagraph~~ (17) shall
2 impair, abridge, or abrogate the right of a member to:

3 (1) directly disclose his or her financial records
4 to the Department or any other person; or

5 (2) authorize his or her attorney or duly appointed
6 agent to request and obtain the member's financial
7 records and disclose those financial records to the
8 Department.

9 (g) ~~(f)~~ For purposes of this item ~~subparagraph~~ (17),
10 "Department" means the Department of Human Services and the
11 Department of Healthcare and Family Services or any
12 successor administrative agency of either agency. Nothing
13 in this item (17) is intended to impair the Department's
14 ability to operate an asset verification system in
15 accordance with 42 U.S.C. 1396w, provided the customer's
16 authorization is obtained by the Department.

17 (18) ~~(17)~~ The furnishing of the financial records of a
18 member to an appropriate law enforcement authority,
19 without prior notice to or consent of the member, upon
20 written request of the law enforcement authority, when
21 reasonable suspicion of an imminent threat to the personal
22 security and safety of the member exists that necessitates
23 an expedited release of the member's financial records, as
24 determined by the law enforcement authority. The law
25 enforcement authority shall include a brief explanation of
26 the imminent threat to the member in its written request to

1 the credit union. The written request shall reflect that it
2 has been authorized by a supervisory or managerial official
3 of the law enforcement authority. The decision to furnish
4 the financial records of a member to a law enforcement
5 authority shall be made by a supervisory or managerial
6 official of the credit union. A credit union providing
7 information in accordance with this item (18) ~~(17)~~ shall
8 not be liable to the member or any other person for the
9 disclosure of the information to the law enforcement
10 authority.

11 (c) Except as otherwise provided by this Act, a credit
12 union may not disclose to any person, except to the member or
13 his duly authorized agent, any financial records relating to
14 that member of the credit union unless:

15 (1) the member has authorized disclosure to the person;

16 (2) the financial records are disclosed in response to
17 a lawful subpoena, summons, warrant, citation to discover
18 assets, or court order that meets the requirements of
19 subparagraph (3) (d) ~~(d)~~ of this Section; or

20 (3) the credit union is attempting to collect an
21 obligation owed to the credit union and the credit union
22 complies with the provisions of Section 2I of the Consumer
23 Fraud and Deceptive Business Practices Act.

24 (d) A credit union shall disclose financial records under
25 item (3) (c) (2) ~~subparagraph (c) (2)~~ of this Section pursuant to
26 a lawful subpoena, summons, warrant, citation to discover

1 assets, or court order only after the credit union mails a copy
2 of the subpoena, summons, warrant, citation to discover assets,
3 or court order to the person establishing the relationship with
4 the credit union, if living, and otherwise his personal
5 representative, if known, at his last known address by first
6 class mail, postage prepaid unless the credit union is
7 specifically prohibited from notifying the person by order of
8 court or by applicable State or federal law. In the case of a
9 grand jury subpoena, a credit union shall not mail a copy of a
10 subpoena to any person pursuant to this subsection if the
11 subpoena was issued by a grand jury under the Statewide Grand
12 Jury Act or notifying the person would constitute a violation
13 of the federal Right to Financial Privacy Act of 1978.

14 (e)(1) Any officer or employee of a credit union who
15 knowingly and willfully ~~wilfully~~ furnishes financial records
16 in violation of this Section is guilty of a business offense
17 and upon conviction thereof shall be fined not more than
18 \$1,000.

19 (2) Any person who knowingly and willfully ~~wilfully~~ induces
20 or attempts to induce any officer or employee of a credit union
21 to disclose financial records in violation of this Section is
22 guilty of a business offense and upon conviction thereof shall
23 be fined not more than \$1,000.

24 (f) A credit union shall be reimbursed for costs which are
25 reasonably necessary and which have been directly incurred in
26 searching for, reproducing or transporting books, papers,

1 records or other data of a member required or requested to be
2 produced pursuant to a lawful subpoena, summons, warrant,
3 citation to discover assets, or court order. The Secretary and
4 the Director may determine, by rule, the rates and conditions
5 under which payment shall be made. Delivery of requested
6 documents may be delayed until final reimbursement of all costs
7 is received.

8 (Source: P.A. 99-143, eff. 7-27-15; 100-22, eff. 1-1-18;
9 100-664, eff. 1-1-19; 100-778, eff. 8-10-18; revised
10 10-18-18.)

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

13 (215 ILCS 106/7)

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

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

24 (1) By no later than July 1, 2011, require verification

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

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

1 information available to the Department as a result of the
2 recipient's application for other non-health care
3 benefits, that is sufficient to make a determination of
4 continued eligibility for medical assistance or for
5 benefits provided under the Program may be reviewed and
6 verified, and subsequent action taken including client
7 notification of continued eligibility for medical
8 assistance or for benefits provided under the Program. The
9 date of client notification establishes the date for
10 subsequent annual eligibility reviews. If a recipient does
11 not fulfill the requirements for continued eligibility by
12 the deadline established in the notice, a notice of
13 cancellation shall be issued to the recipient and coverage
14 shall end no later than the last day of the month following
15 ~~on~~ the last day of the eligibility period. A recipient's
16 eligibility may be reinstated without requiring a new
17 application if the recipient fulfills the requirements for
18 continued eligibility prior to the end of the third month
19 following the last date of coverage (or longer period if
20 required by federal regulations). Nothing in this Section
21 shall prevent an individual whose coverage has been
22 cancelled from reapplying for health benefits at any time.

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

25 (b) The Department shall establish or continue cooperative
26 arrangements with the Social Security Administration, the

1 Illinois Secretary of State, the Department of Human Services,
2 the Department of Revenue, the Department of Employment
3 Security, and any other appropriate entity to gain electronic
4 access, to the extent allowed by law, to information available
5 to those entities that may be appropriate for electronically
6 verifying any factor of eligibility for benefits under the
7 Program. Data relevant to eligibility shall be provided for no
8 other purpose than to verify the eligibility of new applicants
9 or current recipients of health benefits under the Program.
10 Data will be requested or provided for any new applicant or
11 current recipient only insofar as that individual's
12 circumstances are relevant to that individual's or another
13 individual's eligibility.

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

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

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

22 (215 ILCS 170/7)

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

24 Sec. 7. Eligibility verification. Notwithstanding any

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

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

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

20 (2) By October 1, 2011, require verification of, at a
21 minimum, one month's income from all sources required for
22 determining the continued eligibility of recipients at
23 their annual review of eligibility under the Program. Such
24 verification shall take the form of pay stubs, business or
25 income and expense records for self-employed persons,
26 letters from employers, and any other valid documentation

1 of income including data obtained electronically by the
2 Department or its designees from other sources as described
3 in subsection (b) of this Section. A month's income may be
4 verified by a single pay stub with the monthly income
5 extrapolated from the time period covered by the pay stub.

6 The Department shall send a notice to recipients at least
7 60 days prior to the end of their period of eligibility
8 that informs them of the requirements for continued
9 eligibility. Information the Department receives prior to
10 the annual review, including information available to the
11 Department as a result of the recipient's application for
12 other non-health care benefits, that is sufficient to make
13 a determination of continued eligibility for benefits
14 provided under this Act, the Children's Health Insurance
15 Program Act, or Article V of the Illinois Public Aid Code
16 may be reviewed and verified, and subsequent action taken
17 including client notification of continued eligibility for
18 benefits provided under this Act, the Children's Health
19 Insurance Program Act, or Article V of the Illinois Public
20 Aid Code. The date of client notification establishes the
21 date for subsequent annual eligibility reviews. If a
22 recipient does not fulfill the requirements for continued
23 eligibility by the deadline established in the notice, a
24 notice of cancellation shall be issued to the recipient and
25 coverage shall end no later than the last day of the month
26 following ~~on~~ the last day of the eligibility period. A

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

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

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

26 (c) Within 90 days of the effective date of this amendatory

1 Act of the 96th General Assembly, the Department of Healthcare
2 and Family Services shall send notice to current recipients
3 informing them of the changes regarding their eligibility
4 verification.

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

6 Section 40. The Illinois Public Aid Code is amended by
7 changing Sections 5-4.1, 5-5, 5-5f, 5-30.1, 5A-4, 11-5.1,
8 11-5.3, 11-5.4, and 12-4.42 and by adding Sections 5-5.10,
9 5-30.12, and 14-13 as follows:

10 (305 ILCS 5/5-4.1) (from Ch. 23, par. 5-4.1)

11 Sec. 5-4.1. Co-payments. The Department may by rule provide
12 that recipients under any Article of this Code shall pay a
13 federally approved fee as a co-payment for services. No ~~provide~~
14 ~~that recipients under any Article of this Code shall pay a fee~~
15 ~~as a co payment for services. Co payments shall be maximized to~~
16 ~~the extent permitted by federal law, except that the Department~~
17 ~~shall impose a co pay of \$2 on generic drugs. Provided,~~
18 ~~however, that any such rule must provide that no co-payment~~
19 requirement can exist for renal dialysis, radiation therapy,
20 cancer chemotherapy, or insulin, and other products necessary
21 on a recurring basis, the absence of which would be life
22 threatening, or where co-payment expenditures for required
23 services and/or medications for chronic diseases that the
24 Illinois Department shall by rule designate shall cause an

1 extensive financial burden on the recipient, and provided no
2 co-payment shall exist for emergency room encounters which are
3 for medical emergencies. The Department shall seek approval of
4 a State plan amendment that allows pharmacies to refuse to
5 dispense drugs in circumstances where the recipient does not
6 pay the required co-payment. Co-payments may not exceed \$10 for
7 emergency room use for a non-emergency situation as defined by
8 the Department by rule and subject to federal approval.

9 (Source: P.A. 96-1501, eff. 1-25-11; 97-74, eff. 6-30-11;
10 97-689, eff. 6-14-12.)

11 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

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

1 arising from the sexual assault; (16) the diagnosis and
2 treatment of sickle cell anemia; and (17) any other medical
3 care, and any other type of remedial care recognized under the
4 laws of this State. The term "any other type of remedial care"
5 shall include nursing care and nursing home service for persons
6 who rely on treatment by spiritual means alone through prayer
7 for healing.

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

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

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

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

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

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

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

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

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

25 Notwithstanding any other provision of this Code and
26 subject to federal approval, the Department may adopt rules to

1 allow a dentist who is volunteering his or her service at no
2 cost to render dental services through an enrolled
3 not-for-profit health clinic without the dentist personally
4 enrolling as a participating provider in the medical assistance
5 program. A not-for-profit health clinic shall include a public
6 health clinic or Federally Qualified Health Center or other
7 enrolled provider, as determined by the Department, through
8 which dental services covered under this Section are performed.
9 The Department shall establish a process for payment of claims
10 for reimbursement for covered dental services rendered under
11 this provision.

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

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

22 The Illinois Department shall authorize the provision of,
23 and shall authorize payment for, screening by low-dose
24 mammography for the presence of occult breast cancer for women
25 35 years of age or older who are eligible for medical
26 assistance under this Article, as follows:

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

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

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

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

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

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

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

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

25 On and after January 1, 2012, providers participating in a
26 quality improvement program approved by the Department shall be

1 reimbursed for screening and diagnostic mammography at the same
2 rate as the Medicare program's rates, including the increased
3 reimbursement for digital mammography.

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

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

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

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

1 The Department shall establish a methodology to remind
2 women who are age-appropriate for screening mammography, but
3 who have not received a mammogram within the previous 18
4 months, of the importance and benefit of screening mammography.
5 The Department shall work with experts in breast cancer
6 outreach and patient navigation to optimize these reminders and
7 shall establish a methodology for evaluating their
8 effectiveness and modifying the methodology based on the
9 evaluation.

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

16 The Department shall devise a means of case-managing or
17 patient navigation for beneficiaries diagnosed with breast
18 cancer. This program shall initially operate as a pilot program
19 in areas of the State with the highest incidence of mortality
20 related to breast cancer. At least one pilot program site shall
21 be in the metropolitan Chicago area and at least one site shall
22 be outside the metropolitan Chicago area. On or after July 1,
23 2016, the pilot program shall be expanded to include one site
24 in western Illinois, one site in southern Illinois, one site in
25 central Illinois, and 4 sites within metropolitan Chicago. An
26 evaluation of the pilot program shall be carried out measuring

1 health outcomes and cost of care for those served by the pilot
2 program compared to similarly situated patients who are not
3 served by the pilot program.

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

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

23 All medical providers providing medical assistance to
24 pregnant women under this Code shall receive information from
25 the Department on the availability of services under any
26 program providing case management services for addicted women,

1 including information on appropriate referrals for other
2 social services that may be needed by addicted women in
3 addition to treatment for addiction.

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

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

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

24 The Illinois Department may develop and contract with
25 Partnerships of medical providers to arrange medical services
26 for persons eligible under Section 5-2 of this Code.

1 Implementation of this Section may be by demonstration projects
2 in certain geographic areas. The Partnership shall be
3 represented by a sponsor organization. The Department, by rule,
4 shall develop qualifications for sponsors of Partnerships.
5 Nothing in this Section shall be construed to require that the
6 sponsor organization be a medical organization.

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

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

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

25 (3) Persons receiving medical services through
26 Partnerships may receive medical and case management

1 services above the level usually offered through the
2 medical assistance program.

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

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

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

24 The Illinois Department shall require health care
25 providers to maintain records that document the medical care
26 and services provided to recipients of Medical Assistance under

1 this Article. Such records must be retained for a period of not
2 less than 6 years from the date of service or as provided by
3 applicable State law, whichever period is longer, except that
4 if an audit is initiated within the required retention period
5 then the records must be retained until the audit is completed
6 and every exception is resolved. The Illinois Department shall
7 require health care providers to make available, when
8 authorized by the patient, in writing, the medical records in a
9 timely fashion to other health care providers who are treating
10 or serving persons eligible for Medical Assistance under this
11 Article. All dispensers of medical services shall be required
12 to maintain and retain business and professional records
13 sufficient to fully and accurately document the nature, scope,
14 details and receipt of the health care provided to persons
15 eligible for medical assistance under this Code, in accordance
16 with regulations promulgated by the Illinois Department. The
17 rules and regulations shall require that proof of the receipt
18 of prescription drugs, dentures, prosthetic devices and
19 eyeglasses by eligible persons under this Section accompany
20 each claim for reimbursement submitted by the dispenser of such
21 medical services. No such claims for reimbursement shall be
22 approved for payment by the Illinois Department without such
23 proof of receipt, unless the Illinois Department shall have put
24 into effect and shall be operating a system of post-payment
25 audit and review which shall, on a sampling basis, be deemed
26 adequate by the Illinois Department to assure that such drugs,

1 dentures, prosthetic devices and eyeglasses for which payment
2 is being made are actually being received by eligible
3 recipients. Within 90 days after September 16, 1984 (the
4 effective date of Public Act 83-1439), the Illinois Department
5 shall establish a current list of acquisition costs for all
6 prosthetic devices and any other items recognized as medical
7 equipment and supplies reimbursable under this Article and
8 shall update such list on a quarterly basis, except that the
9 acquisition costs of all prescription drugs shall be updated no
10 less frequently than every 30 days as required by Section
11 5-5.12.

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

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

1 Act and MC/DD facilities licensed under the MC/DD Act to submit
2 monthly billing claims for reimbursement purposes. Following
3 development of these procedures, the Department shall have an
4 additional 365 days to test the viability of the new system and
5 to ensure that any necessary operational or structural changes
6 to its information technology platforms are implemented.

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

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

24 Enrollment of a vendor shall be subject to a provisional
25 period and shall be conditional for one year. During the period
26 of conditional enrollment, the Department may terminate the

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

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

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

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

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

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

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

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

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

25 (4) In the case of a provider operated by a unit of
26 local government with a population exceeding 3,000,000

1 when local government funds finance federal participation
2 for claims payments.

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

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

25 Claims that are not submitted and received in compliance
26 with the foregoing requirements shall not be eligible for

1 payment under the medical assistance program, and the State
2 shall have no liability for payment of those claims.

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

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

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

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

21 The Illinois Department shall establish policies,
22 procedures, standards and criteria by rule for the acquisition,
23 repair and replacement of orthotic and prosthetic devices and
24 durable medical equipment. Such rules shall provide, but not be
25 limited to, the following services: (1) immediate repair or
26 replacement of such devices by recipients; and (2) rental,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 Because kidney transplantation can be an appropriate,
18 cost-effective alternative to renal dialysis when medically
19 necessary and notwithstanding the provisions of Section 1-11 of
20 this Code, beginning October 1, 2014, the Department shall
21 cover kidney transplantation for noncitizens with end-stage
22 renal disease who are not eligible for comprehensive medical
23 benefits, who meet the residency requirements of Section 5-3 of
24 this Code, and who would otherwise meet the financial
25 requirements of the appropriate class of eligible persons under
26 Section 5-2 of this Code. To qualify for coverage of kidney

1 transplantation, such person must be receiving emergency renal
2 dialysis services covered by the Department. Providers under
3 this Section shall be prior approved and certified by the
4 Department to perform kidney transplantation and the services
5 under this Section shall be limited to services associated with
6 kidney transplantation.

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

18 On or after July 1, 2015, opioid antagonists prescribed for
19 the treatment of an opioid overdose, including the medication
20 product, administration devices, and any pharmacy fees related
21 to the dispensing and administration of the opioid antagonist,
22 shall be covered under the medical assistance program for
23 persons who are otherwise eligible for medical assistance under
24 this Article. As used in this Section, "opioid antagonist"
25 means a drug that binds to opioid receptors and blocks or
26 inhibits the effect of opioids acting on those receptors,

1 including, but not limited to, naloxone hydrochloride or any
2 other similarly acting drug approved by the U.S. Food and Drug
3 Administration.

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

16 A federally qualified health center, as defined in Section
17 1905(1)(2)(B) of the federal Social Security Act, shall be
18 reimbursed by the Department in accordance with the federally
19 qualified health center's encounter rate for services provided
20 to medical assistance recipients that are performed by a dental
21 hygienist, as defined under the Illinois Dental Practice Act,
22 working under the general supervision of a dentist and employed
23 by a federally qualified health center.

24 ~~Notwithstanding any other provision of this Code, the~~
25 ~~Illinois Department shall authorize licensed dietitian~~
26 ~~nutritionists and certified diabetes educators to counsel~~

1 ~~senior diabetes patients in the senior diabetes patients' homes~~
2 ~~to remove the hurdle of transportation for senior diabetes~~
3 ~~patients to receive treatment.~~

4 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
5 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
6 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;
7 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
8 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,
9 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
10 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff.
11 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18;
12 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff.
13 12-10-18.)

14 (305 ILCS 5/5-5.10 new)

15 Sec. 5-5.10. Value-based purchasing.

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

1 (b) The Department of Healthcare and Family Services and
2 the Department of Human Services shall initiate discussions
3 with mental health providers, substance abuse providers,
4 managed care organizations, advocacy groups for individuals
5 with behavioral health issues, and others, as appropriate, no
6 later than July 1, 2019. A model for value-based purchasing for
7 behavioral health providers shall be presented to the General
8 Assembly by January 31, 2020. In developing this model, the
9 Department of Healthcare and Family Services shall develop
10 projections of the funding necessary for the model.

11 (305 ILCS 5/5-5f)

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

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

20 (b) The Department shall place the following
21 limitations on services: (i) the Department shall limit
22 adult eyeglasses to one pair every 2 years; however, the
23 limitation does not apply to an individual who needs
24 different eyeglasses following a surgical procedure such
25 as cataract surgery; (ii) the Department shall set an

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

1 and dental services necessary for the health of a pregnant
2 woman prior to delivery of her baby shall continue to be
3 covered; and (vi) effective July 1, 2012, the Department
4 shall place limitations and require concurrent review on
5 every inpatient detoxification stay to prevent repeat
6 admissions to any hospital for detoxification within 60
7 days of a previous inpatient detoxification stay. The
8 Department shall convene a workgroup of hospitals,
9 substance abuse providers, care coordination entities,
10 managed care plans, and other stakeholders to develop
11 recommendations for quality standards, diversion to other
12 settings, and admission criteria for patients who need
13 inpatient detoxification, which shall be published on the
14 Department's website no later than September 1, 2013.

15 (c) The Department shall require prior approval of the
16 following services: wheelchair repairs costing more than
17 \$400, coronary artery bypass graft, and bariatric surgery
18 consistent with Medicare standards concerning patient
19 responsibility. Wheelchair repair prior approval requests
20 shall be adjudicated within one business day of receipt of
21 complete supporting documentation. Providers may not break
22 wheelchair repairs into separate claims for purposes of
23 staying under the \$400 threshold for requiring prior
24 approval. The wholesale price of manual and power
25 wheelchairs, durable medical equipment and supplies, and
26 complex rehabilitation technology products and services

1 shall be defined as actual acquisition cost including all
2 discounts.

3 (d) The Department shall establish benchmarks for
4 hospitals to measure and align payments to reduce
5 potentially preventable hospital readmissions, inpatient
6 complications, and unnecessary emergency room visits. In
7 doing so, the Department shall consider items, including,
8 but not limited to, historic and current acuity of care and
9 historic and current trends in readmission. The Department
10 shall publish provider-specific historical readmission
11 data and anticipated potentially preventable targets 60
12 days prior to the start of the program. In the instance of
13 readmissions, the Department shall adopt policies and
14 rates of reimbursement for services and other payments
15 provided under this Code to ensure that, by June 30, 2013,
16 expenditures to hospitals are reduced by, at a minimum,
17 \$40,000,000.

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

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

1 technology.

2 (g) For the Home Services Program operated by the
3 Department of Human Services and the Community Care Program
4 operated by the Department on Aging, the Department of
5 Human Services, in cooperation with the Department on
6 Aging, shall implement an electronic service verification
7 based on global positioning systems or other
8 cost-effective technology.

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

16 As used in this subsection (h):

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

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

26 (i) The Department shall implement cost savings

1 initiatives for advanced imaging services, cardiac imaging
2 services, pain management services, and back surgery. Such
3 initiatives shall be designed to achieve annual costs
4 savings.

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

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

10 (305 ILCS 5/5-30.1)

11 Sec. 5-30.1. Managed care protections.

12 (a) As used in this Section:

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

16 "Emergency services" include:

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

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

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

25 (4) emergency medical conditions, as defined by

1 Section 10 of the Managed Care Reform and Patient Rights
2 Act.

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

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

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

18 (1) the MCO authorized such services;

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

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

25 (4) the MCO could not be contacted; or

26 (5) the MCO and the treating provider, if the treating

1 provider is a non-affiliated provider, could not reach an
2 agreement concerning the enrollee's care and an affiliated
3 provider was unavailable for a consultation, in which case
4 the MCO must pay for such services rendered by the treating
5 non-affiliated provider until an affiliated provider was
6 reached and either concurred with the treating
7 non-affiliated provider's plan of care or assumed
8 responsibility for the enrollee's care. Such payment shall
9 be made at the default rate of reimbursement paid under
10 Illinois Medicaid fee-for-service program methodology,
11 including all policy adjusters, including but not limited
12 to Medicaid High Volume Adjustments, Medicaid Percentage
13 Adjustments, Outpatient High Volume Adjustments and all
14 outlier add-on adjustments to the extent that such
15 adjustments are incorporated in the development of the
16 applicable MCO capitated rates.

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

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

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

26 (3) The MCO shall have no obligation to cover medical

1 services provided on an emergency basis that are not
2 covered services under the contract.

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

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

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

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

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

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

25 (D) the enrollee is discharged.

26 (f) Network adequacy and transparency.

1 (1) The Department shall:

2 (A) ensure that an adequate provider network is in
3 place, taking into consideration health professional
4 shortage areas and medically underserved areas;

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

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

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

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

21 (g) Timely payment of claims.

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

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

1 that claim.

2 (3) The MCO shall pay a penalty that is at least equal
3 to the timely payment interest penalty imposed under
4 Section 368a of the Illinois Insurance Code for any claims
5 not timely paid.

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

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

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

23 (B) Compliance with the expedited provider requirement
24 may be satisfied by an MCO through the use of a Periodic
25 Interim Payment (PIP) program that has been mutually agreed
26 to and documented between the MCO and the provider, and the

1 PIP program ensures that any expedited provider receives
2 regular and periodic payments based on prior period payment
3 experience from that MCO. Total payments under the PIP
4 program may be reconciled against future PIP payments on a
5 schedule mutually agreed to between the MCO and the
6 provider.

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

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

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

25 (2) the Department shall, by December 31, 2016, adopt
26 rules establishing policies that shall be included in the

1 Medicaid managed care policy and procedures manual
2 addressing payment resolutions in situations in which a
3 provider renders services based upon information obtained
4 after verifying a patient's eligibility and coverage plan
5 through either the Department's current enrollment system
6 or a system operated by the coverage plan identified by the
7 patient presenting for services:

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

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

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

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

22 (A) the extension of the timely filing period;

23 (B) retroactive prior authorizations; and

24 (C) guaranteed minimum payment rate of no less than the
25 current, as of the date of service, fee-for-service rate,
26 plus all applicable add-ons, when the resulting service

1 relationship is out of network.

2 ~~(4)~~ The rules shall be applicable for both MCO coverage and
3 fee-for-service coverage.

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

8 (g-6) MCO Performance Metrics Report.

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

13 (A) claims payment, including timeliness and
14 accuracy;

15 (B) prior authorizations;

16 (C) grievance and appeals;

17 (D) utilization statistics;

18 (E) provider disputes;

19 (F) provider credentialing; and

20 (G) member and provider customer service.

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

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

1 identified industry.

2 (4) Metrics shall be defined and incorporated into the
3 applicable Managed Care Policy Manual issued by the
4 Department.

5 (g-7) MCO claims processing and performance analysis. In
6 order to monitor MCO payments to hospital providers, pursuant
7 to this amendatory Act of the 100th General Assembly, the
8 Department shall post an analysis of MCO claims processing and
9 payment performance on its website every 6 months. Such
10 analysis shall include a review and evaluation of a
11 representative sample of hospital claims that are rejected and
12 denied for clean and unclean claims and the top 5 reasons for
13 such actions and timeliness of claims adjudication, which
14 identifies the percentage of claims adjudicated within 30, 60,
15 90, and over 90 days, and the dollar amounts associated with
16 those claims. The Department shall post the contracted claims
17 report required by HealthChoice Illinois on its website every 3
18 months.

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

1 itself of the MCO's internal dispute resolution process.
2 Disputes that are submitted to the MCO internal dispute
3 resolution process may be submitted to the Department of
4 Healthcare and Family Services' complaint portal no sooner than
5 30 days after submitting to the MCO's internal process and not
6 later than 30 days after the unsatisfactory resolution of the
7 internal MCO process or 60 days after submitting the dispute to
8 the MCO internal process. Multiple claim disputes involving the
9 same MCO may be submitted in one complaint, regardless of
10 whether the claims are for different enrollees, when the
11 specific reason for non-payment of the claims involves a common
12 question of fact or policy. Within 10 business days of receipt
13 of a complaint, the Department shall present such disputes to
14 the appropriate MCO, which shall then have 30 days to issue its
15 written proposal to resolve the dispute. The Department may
16 grant one 30-day extension of this time frame to one of the
17 parties to resolve the dispute. If the dispute remains
18 unresolved at the end of this time frame or the provider is not
19 satisfied with the MCO's written proposal to resolve the
20 dispute, the provider may, within 30 days, request the
21 Department to review the dispute and make a final
22 determination. Within 30 days of the request for Department
23 review of the dispute, both the provider and the MCO shall
24 present all relevant information to the Department for
25 resolution and make individuals with knowledge of the issues
26 available to the Department for further inquiry if needed.

1 Within 30 days of receiving the relevant information on the
2 dispute, or the lapse of the period for submitting such
3 information, the Department shall issue a written decision on
4 the dispute based on contractual terms between the provider and
5 the MCO, contractual terms between the MCO and the Department
6 of Healthcare and Family Services and applicable Medicaid
7 policy. The decision of the Department shall be final. By
8 January 1, 2020, the Department shall establish by rule further
9 details of this dispute resolution process. Disputes between
10 MCOs and providers presented to the Department for resolution
11 are not contested cases, as defined in Section 1-30 of the
12 Illinois Administrative Procedure Act, conferring any right to
13 an administrative hearing.

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

17 (A) Premium revenue, with appropriate adjustments.

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

20 (i) Direct paid claims.

21 (ii) Subcapitation payments.

22 (iii) Other claim payments.

23 (iv) Direct reserves.

24 (v) Gross recoveries.

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

1 (2) The medical loss ratio shall be calculated consistent
2 with federal law and regulation following a claims runout
3 period determined by the Department.

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

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

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

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

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

23 (3) By October 1, 2019, the Department shall require all
24 MCOs to update their provider directory with information for
25 new practitioners of existing contracted providers within 30
26 days of receipt of a complete and accurate standardized roster

1 template in the format approved by the Department provided that
2 the provider is effective in the Department's provider
3 enrollment subsystem within the IMPACT system. Such provider
4 directory shall be readily accessible for purposes of selecting
5 an approved health care provider and comply with all other
6 federal and State requirements.

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

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

1 (i) The requirements of this Section apply to contracts
2 with accountable care entities and MCOs entered into, amended,
3 or renewed after June 16, 2014 (the effective date of Public
4 Act 98-651).

5 (j) Health care information released to managed care
6 organizations. A health care provider shall release to a
7 Medicaid managed care organization, upon request, and subject
8 to the Health Insurance Portability and Accountability Act of
9 1996 and any other law applicable to the release of health
10 information, the health care information of the MCO's enrollee,
11 if the enrollee has completed and signed a general release form
12 that grants to the health care provider permission to release
13 the recipient's health care information to the recipient's
14 insurance carrier.

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

18 (305 ILCS 5/5-30.12 new)

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

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

1 needs:

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

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

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

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

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

1 adjudication.

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

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

11 (c) Neither the technology nor MCO policy shall require
12 providers to submit claims through a process other than the
13 pipeline. MCOs may request supplemental information needed for
14 adjudication which cannot be contained in the claim file to be
15 submitted separately to the MCOs.

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

19 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

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

21 (a) The assessment imposed by Section 5A-2 for State fiscal
22 year 2009 through State fiscal year 2018 or as provided in
23 Section 5A-16, shall be due and payable in monthly
24 installments, each equaling one-twelfth of the assessment for
25 the year, on the fourteenth State business day of each month.

1 No installment payment of an assessment imposed by Section 5A-2
2 shall be due and payable, however, until after the Comptroller
3 has issued the payments required under this Article.

4 Except as provided in subsection (a-5) of this Section, the
5 assessment imposed by subsection (b-5) of Section 5A-2 for the
6 portion of State fiscal year 2012 beginning June 10, 2012
7 through June 30, 2012, and for State fiscal year 2013 through
8 State fiscal year 2018 or as provided in Section 5A-16, shall
9 be due and payable in monthly installments, each equaling
10 one-twelfth of the assessment for the year, on the 17th State
11 business day of each month. No installment payment of an
12 assessment imposed by subsection (b-5) of Section 5A-2 shall be
13 due and payable, however, until after: (i) the Department
14 notifies the hospital provider, in writing, that the payment
15 methodologies to hospitals required under Section 5A-12.4,
16 have been approved by the Centers for Medicare and Medicaid
17 Services of the U.S. Department of Health and Human Services,
18 and the waiver under 42 CFR 433.68 for the assessment imposed
19 by subsection (b-5) of Section 5A-2, if necessary, has been
20 granted by the Centers for Medicare and Medicaid Services of
21 the U.S. Department of Health and Human Services; and (ii) the
22 Comptroller has issued the payments required under Section
23 5A-12.4. Upon notification to the Department of approval of the
24 payment methodologies required under Section 5A-12.4 and the
25 waiver granted under 42 CFR 433.68, if necessary, all
26 installments otherwise due under subsection (b-5) of Section

1 5A-2 prior to the date of notification shall be due and payable
2 to the Department upon written direction from the Department
3 and issuance by the Comptroller of the payments required under
4 Section 5A-12.4.

5 Except as provided in subsection (a-5) of this Section, the
6 assessment imposed under Section 5A-2 for State fiscal year
7 2019 and each subsequent State fiscal year shall be due and
8 payable in monthly installments, each equaling one-twelfth of
9 the assessment for the year, on the 17th ~~14th~~ State business
10 day of each month. No installment payment of an assessment
11 imposed by Section 5A-2 shall be due and payable, however,
12 until after: (i) the Department notifies the hospital provider,
13 in writing, that the payment methodologies to hospitals
14 required under Section 5A-12.6 have been approved by the
15 Centers for Medicare and Medicaid Services of the U.S.
16 Department of Health and Human Services, and the waiver under
17 42 CFR 433.68 for the assessment imposed by Section 5A-2, if
18 necessary, has been granted by the Centers for Medicare and
19 Medicaid Services of the U.S. Department of Health and Human
20 Services; and (ii) the Comptroller has issued the payments
21 required under Section 5A-12.6. Upon notification to the
22 Department of approval of the payment methodologies required
23 under Section 5A-12.6 and the waiver granted under 42 CFR
24 433.68, if necessary, all installments otherwise due under
25 Section 5A-2 prior to the date of notification shall be due and
26 payable to the Department upon written direction from the

1 Department and issuance by the Comptroller of the payments
2 required under Section 5A-12.6.

3 (a-5) The Illinois Department may accelerate the schedule
4 upon which assessment installments are due and payable by
5 hospitals with a payment ratio greater than or equal to one.
6 Such acceleration of due dates for payment of the assessment
7 may be made only in conjunction with a corresponding
8 acceleration in access payments identified in Section 5A-12.2,
9 Section 5A-12.4, or Section 5A-12.6 to the same hospitals. For
10 the purposes of this subsection (a-5), a hospital's payment
11 ratio is defined as the quotient obtained by dividing the total
12 payments for the State fiscal year, as authorized under Section
13 5A-12.2, Section 5A-12.4, or Section 5A-12.6, by the total
14 assessment for the State fiscal year imposed under Section 5A-2
15 or subsection (b-5) of Section 5A-2.

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

21 (c) If a hospital provider fails to pay the full amount of
22 an installment when due (including any extensions granted under
23 subsection (b)), there shall, unless waived by the Illinois
24 Department for reasonable cause, be added to the assessment
25 imposed by Section 5A-2 a penalty assessment equal to the
26 lesser of (i) 5% of the amount of the installment not paid on

1 or before the due date plus 5% of the portion thereof remaining
2 unpaid on the last day of each 30-day period thereafter or (ii)
3 100% of the installment amount not paid on or before the due
4 date. For purposes of this subsection, payments will be
5 credited first to unpaid installment amounts (rather than to
6 penalty or interest), beginning with the most delinquent
7 installments.

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

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

16 (305 ILCS 5/11-5.1)

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

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

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

13 (2) By no later than October 1, 2011, require
14 verification of, at a minimum, one month's income from all
15 sources required for determining the continued eligibility
16 of recipients at their annual review of eligibility for
17 medical assistance under this Code. Information the
18 Department receives prior to the annual review, including
19 information available to the Department as a result of the
20 recipient's application for other non-Medicaid benefits,
21 that is sufficient to make a determination of continued
22 Medicaid eligibility may be reviewed and verified, and
23 subsequent action taken including client notification of
24 continued Medicaid eligibility. The date of client
25 notification establishes the date for subsequent annual
26 Medicaid eligibility reviews. Such verification shall take

1 the form of pay stubs, business or income and expense
2 records for self-employed persons, letters from employers,
3 and any other valid documentation of income including data
4 obtained electronically by the Department or its designees
5 from other sources as described in subsection (b) of this
6 Section. A month's income may be verified by a single pay
7 stub with the monthly income extrapolated from the time
8 period covered by the pay stub. The Department shall send a
9 notice to recipients at least 60 days prior to the end of
10 their period of eligibility that informs them of the
11 requirements for continued eligibility. If a recipient
12 does not fulfill the requirements for continued
13 eligibility by the deadline established in the notice a
14 notice of cancellation shall be issued to the recipient and
15 coverage shall end no later than the last day of the month
16 following ~~on~~ the last day of the eligibility period. A
17 recipient's eligibility may be reinstated without
18 requiring a new application if the recipient fulfills the
19 requirements for continued eligibility prior to the end of
20 the third month following the last date of coverage (or
21 longer period if required by federal regulations). Nothing
22 in this Section shall prevent an individual whose coverage
23 has been cancelled from reapplying for health benefits at
24 any time.

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

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

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

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

24 (d) As soon as practical if the data is reasonably
25 available, but no later than January 1, 2017, the Department
26 shall compile on a monthly basis data on eligibility

1 redeterminations of beneficiaries of medical assistance
2 provided under Article V of this Code. This data shall be
3 posted on the Department's website, and data from prior months
4 shall be retained and available on the Department's website.
5 The data compiled and reported shall include the following:

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

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

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

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

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

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

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

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

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

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

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

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

1 cancellations due to each of the reasons listed under
2 paragraph (3) of this subsection.

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

13 (1) Recipients of developmental disabilities services.

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

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

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

20 (5) Populations with no verifiable income.

21 (6) Self-employed people.

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

25 (f) The Department shall explore and implement, as
26 practical and technologically possible, roles that

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

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

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

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

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

23 (B) Medical redeterminations completed, including:
24 (i) a breakdown of the number of households that were
25 redetermined ex parte and those that were not; (ii) the
26 reasons households were not redetermined ex parte; and

1 (iii) the relative percentages of these reasons.

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

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

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

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

15 (305 ILCS 5/11-5.3)

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

18 (a) No later than 60 days after the effective date of this
19 amendatory Act of the 97th General Assembly, the Chief
20 Procurement Officer for General Services, in consultation with
21 the Department of Healthcare and Family Services, shall conduct
22 and complete any procurement necessary to procure a vendor to
23 verify eligibility for assistance under Article V of this Code.
24 Such authority shall include procuring a vendor to assist the
25 Chief Procurement Officer in conducting the procurement. The

1 Chief Procurement Officer and the Department shall jointly
2 negotiate final contract terms with a vendor selected by the
3 Chief Procurement Officer. Within 30 days of selection of an
4 eligibility verification vendor, the Department of Healthcare
5 and Family Services shall enter into a contract with the
6 selected vendor. The Department of Healthcare and Family
7 Services and the Department of Human Services shall cooperate
8 with and provide any information requested by the Chief
9 Procurement Officer to conduct the procurement.

10 (b) Notwithstanding any other provision of law, any
11 procurement or contract necessary to comply with this Section
12 shall be exempt from: (i) the Illinois Procurement Code
13 pursuant to Section 1-10(h) of the Illinois Procurement Code,
14 except that bidders shall comply with the disclosure
15 requirement in Sections 50-10.5(a) through (d), 50-13, 50-35,
16 and 50-37 of the Illinois Procurement Code and a vendor awarded
17 a contract under this Section shall comply with Section 50-37
18 of the Illinois Procurement Code; (ii) any administrative rules
19 of this State pertaining to procurement or contract formation;
20 and (iii) any State or Department policies or procedures
21 pertaining to procurement, contract formation, contract award,
22 and Business Enterprise Program approval.

23 (c) Upon becoming operational, the contractor shall
24 conduct data matches using the name, date of birth, address,
25 and Social Security Number of each applicant and recipient
26 against public records to verify eligibility. The contractor,

1 upon preliminary determination that an enrollee is eligible or
2 ineligible, shall notify the Department, except that the
3 contractor shall not make preliminary determinations regarding
4 the eligibility of persons residing in long term care
5 facilities whose income and resources were at or below the
6 applicable financial eligibility standards at the time of their
7 last review. Within 20 business days of such notification, the
8 Department shall accept the recommendation or reject it with a
9 stated reason. The Department shall retain final authority over
10 eligibility determinations. The contractor shall keep a record
11 of all preliminary determinations of ineligibility
12 communicated to the Department. Within 30 days of the end of
13 each calendar quarter, the Department and contractor shall file
14 a joint report on a quarterly basis to the Governor, the
15 Speaker of the House of Representatives, the Minority Leader of
16 the House of Representatives, the Senate President, and the
17 Senate Minority Leader. The report shall include, but shall not
18 be limited to, monthly recommendations of preliminary
19 determinations of eligibility or ineligibility communicated by
20 the contractor, the actions taken on those preliminary
21 determinations by the Department, and the stated reasons for
22 those recommendations that the Department rejected.

23 (d) An eligibility verification vendor contract shall be
24 awarded for an initial 2-year period with up to a maximum of 2
25 one-year renewal options. Nothing in this Section shall compel
26 the award of a contract to a vendor that fails to meet the

1 needs of the Department. A contract with a vendor to assist in
2 the procurement shall be awarded for a period of time not to
3 exceed 6 months.

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

6 (f) The State's Integrated Eligibility System shall be on a
7 3-year audit cycle by the Office of the Auditor General.

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

9 (305 ILCS 5/11-5.4)

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

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

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

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

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

25 (A) Minimize the burden on applicants by

1 collecting only the data necessary to determine
2 eligibility for medical services, long-term care
3 services, and spousal impoverishment offset.

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

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

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

13 (2) The State must expedite the eligibility process for
14 applicants meeting specified guidelines, regardless of the
15 age of the application. The guidelines, subject to federal
16 approval, must include, but need not be limited to, the
17 following individually or collectively:

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

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

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

26 (D) For applicants or recipients with verified

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

8 (3) Subject to federal approval, the Department of
9 Healthcare and Family Services must implement an ex parte
10 renewal process for Medicaid-eligible individuals residing
11 in long-term care facilities. "Renewal" has the same
12 meaning as "redetermination" in State policies,
13 administrative rule, and federal Medicaid law. The ex parte
14 renewal process must be fully operational on or before
15 January 1, 2019.

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

21 (c) The Department of Human Services must adopt policies
22 and procedures to improve communication between long-term care
23 benefits central office personnel, applicants and their
24 representatives, and facilities in which the applicants
25 reside. Such policies and procedures must at a minimum permit
26 applicants and their representatives and the facility in which

1 the applicants reside to speak directly to an individual
2 trained to take telephone inquiries and provide appropriate
3 responses.

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

18 (e) Notwithstanding any other provision of this Code, the
19 Department of Human Services and the Department of Healthcare
20 and Family Services' Office of the Inspector General shall,
21 upon request, allow an applicant additional time to submit
22 information and documents needed as part of a review of
23 available resources or resources transferred during the
24 look-back period. The initial extension shall not exceed 30
25 days. A second extension of 30 days may be granted upon
26 request. Any request for information issued by the State to an

1 applicant shall include the following: an explanation of the
2 information required and the date by which the information must
3 be submitted; a statement that failure to respond in a timely
4 manner can result in denial of the application; a statement
5 that the applicant or the facility in the name of the applicant
6 may seek an extension; and the name and contact information of
7 a caseworker in case of questions. Any such request for
8 information shall also be sent to the facility. In deciding
9 whether to grant an extension, the Department of Human Services
10 or the Department of Healthcare and Family Services' Office of
11 the Inspector General shall take into account what is in the
12 best interest of the applicant. The time limits for processing
13 an application shall be tolled during the period of any
14 extension granted under this subsection.

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

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

1 18 months, over 18 months to 24 months, and over 24 months.

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

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

12 (g) Beginning on July 1, 2017, the Auditor General shall
13 report every 3 years to the General Assembly on the performance
14 and compliance of the Department of Healthcare and Family
15 Services, the Department of Human Services, and the Department
16 on Aging in meeting the requirements of this Section and the
17 federal requirements concerning eligibility determinations for
18 Medicaid long-term care services and supports, and shall report
19 any issues or deficiencies and make recommendations. The
20 Auditor General shall, at a minimum, review, consider, and
21 evaluate the following:

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

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

1 435.912;

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

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

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

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

25 (h) The Department of Healthcare and Family Services shall
26 adopt any rules necessary to administer and enforce any

1 provision of this Section. Rulemaking shall not delay the full
2 implementation of this Section.

3 (Source: P.A. 99-153, eff. 7-28-15; 100-380, eff. 8-25-17;
4 100-665, eff. 8-2-18.)

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

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

8 (a) An expedited long-term care eligibility determination
9 and enrollment system shall be established to reduce long-term
10 care determinations to 90 days or fewer by July 1, 2014 and
11 streamline the long-term care enrollment process.
12 Establishment of the system shall be a joint venture of the
13 Department of Human Services and Healthcare and Family Services
14 and the Department on Aging. The Governor shall name a lead
15 agency no later than 30 days after the effective date of this
16 amendatory Act of the 98th General Assembly to assume
17 responsibility for the full implementation of the
18 establishment and maintenance of the system. Project outcomes
19 shall include an enhanced eligibility determination tracking
20 system accessible to providers and a centralized application
21 review and eligibility determination with all applicants
22 reviewed within 90 days of receipt by the State of a complete
23 application. If the Department of Healthcare and Family
24 Services' Office of the Inspector General determines that there
25 is a likelihood that a non-allowable transfer of assets has

1 occurred, and the facility in which the applicant resides is
2 notified, an extension of up to 90 days shall be permissible.
3 On or before December 31, 2015, a streamlined application and
4 enrollment process shall be put in place based on the following
5 principles:

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

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

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

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

23 (c) The lead agency shall file interim reports with the
24 Chairs and Minority Spokespersons of the House and Senate Human
25 Services Committees no later than September 1, 2013 and on
26 February 1, 2014. The Department of Healthcare and Family

1 Services shall include in the annual Medicaid report for State
2 Fiscal Year 2014 and every fiscal year thereafter information
3 concerning implementation of the provisions of this Section.

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

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

15 (1) The Departments shall review, in collaboration
16 with representatives of affected providers, all forms and
17 procedures currently in use, federal guidelines either
18 suggested or mandated, and staff deployment by September
19 30, 2014 to identify additional measures that can improve
20 long-term care eligibility processing and make adjustments
21 where possible.

22 (2) No later than June 30, 2014, the Department of
23 Healthcare and Family Services shall issue vouchers for
24 advance payments not to exceed \$50,000,000 to nursing
25 facilities with significant outstanding Medicaid liability
26 associated with services provided to residents with

1 Medicaid applications pending and residents facing the
2 greatest delays. Each facility with an advance payment
3 shall state in writing whether its own recoupment schedule
4 will be in 3 or 6 equal monthly installments, as long as
5 all advances are recouped by June 30, 2015.

6 (3) The Department of Healthcare and Family Services'
7 Office of Inspector General and the Department of Human
8 Services shall immediately forgo resource review and
9 review of transfers during the relevant look-back period
10 for applications that were submitted prior to September 1,
11 2013. An applicant who applied prior to September 1, 2013,
12 who was denied for failure to cooperate in providing
13 required information, and whose application was
14 incorrectly reviewed under the wrong look-back period
15 rules may request review and correction of the denial based
16 on this subsection. If found eligible upon review, such
17 applicants shall be retroactively enrolled.

18 (4) As soon as practicable, the Department of
19 Healthcare and Family Services shall implement policies
20 and promulgate rules to simplify financial eligibility
21 verification in the following instances: (A) for
22 applicants or recipients who are receiving Supplemental
23 Security Income payments or who had been receiving such
24 payments at the time they were admitted to a nursing
25 facility and (B) for applicants or recipients with verified
26 income at or below 100% of the federal poverty level when

1 the declared value of their countable resources is no
2 greater than the allowable amounts pursuant to Section 5-2
3 of this Code for classes of eligible persons for whom a
4 resource limit applies. Such simplified verification
5 policies shall apply to community cases as well as
6 long-term care cases.

7 (5) As soon as practicable, but not later than July 1,
8 2014, the Department of Healthcare and Family Services and
9 the Department of Human Services shall jointly begin a
10 special enrollment project by using simplified eligibility
11 verification policies and by redeploying caseworkers
12 trained to handle long-term care cases to prioritize those
13 cases, until the backlog is eliminated and processing time
14 is within 90 days. This project shall apply to applications
15 for long-term care received by the State on or before May
16 15, 2014.

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

25 (7) Effective 30 days after the completion of 3
26 regionally based trainings, nursing facilities shall

1 submit all applications for medical assistance online via
2 the Application for Benefits Eligibility (ABE) website.
3 This requirement shall extend to scanning and uploading
4 with the online application any required additional forms
5 such as the Long Term Care Facility Notification and the
6 Additional Financial Information for Long Term Care
7 Applicants as well as scanned copies of any supporting
8 documentation. Long-term care facility admission documents
9 must be submitted as required in Section 5-5 of this Code.
10 No local Department of Human Services office shall refuse
11 to accept an electronically filed application.

12 (8) Notwithstanding any other provision of this Code,
13 the Department of Human Services and the Department of
14 Healthcare and Family Services' Office of the Inspector
15 General shall, upon request, allow an applicant additional
16 time to submit information and documents needed as part of
17 a review of available resources or resources transferred
18 during the look-back period. The initial extension shall
19 not exceed 30 days. A second extension of 30 days may be
20 granted upon request. Any request for information issued by
21 the State to an applicant shall include the following: an
22 explanation of the information required and the date by
23 which the information must be submitted; a statement that
24 failure to respond in a timely manner can result in denial
25 of the application; a statement that the applicant or the
26 facility in the name of the applicant may seek an

1 extension; and the name and contact information of a
2 caseworker in case of questions. Any such request for
3 information shall also be sent to the facility. In deciding
4 whether to grant an extension, the Department of Human
5 Services or the Department of Healthcare and Family
6 Services' Office of the Inspector General shall take into
7 account what is in the best interest of the applicant. The
8 time limits for processing an application shall be tolled
9 during the period of any extension granted under this
10 subsection.

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

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

26 (B) Percentage of applications and

1 redeterminations pending in the Department of Human
2 Services' Family Community Resource Centers, in the
3 Department of Human Services' long-term care hubs,
4 with the Department of Healthcare and Family Services'
5 Office of Inspector General, and those applications
6 which are being tolled due to requests for extension of
7 time for additional information.

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

10 (f) Beginning on July 1, 2017, the Auditor General shall
11 report every 3 years to the General Assembly on the performance
12 and compliance of the Department of Healthcare and Family
13 Services, the Department of Human Services, and the Department
14 on Aging in meeting the requirements of this Section and the
15 federal requirements concerning eligibility determinations for
16 Medicaid long-term care services and supports, and shall report
17 any issues or deficiencies and make recommendations. The
18 Auditor General shall, at a minimum, review, consider, and
19 evaluate the following:

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

23 (2) compliance with federal regulations on the timely
24 determination of eligibility as provided under 42 CFR
25 435.912;

26 (3) the accuracy and completeness of the report

1 required under paragraph (9) of subsection (e);

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

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

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

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

1 (h) Beginning on June 29, 2018, provisional eligibility for
2 medical assistance under Article V of this Code, in the form of
3 a recipient identification number and any other necessary
4 credentials to permit an applicant to receive covered services
5 under Article V ~~benefits~~, must be issued to any applicant who
6 has not received a ~~final eligibility~~ determination on his or
7 her application for Medicaid and Medicaid long-term care
8 services filed simultaneously or, if already Medicaid
9 enrolled, application for ~~or~~ Medicaid long-term care services
10 under Article V of this Code ~~benefits or a notice of an~~
11 ~~opportunity for a hearing~~ within the federally prescribed
12 timeliness requirements for determinations on ~~deadlines for~~
13 ~~the processing of~~ such applications. The Department must
14 maintain the applicant's provisional eligibility ~~Medicaid~~
15 ~~enrollment~~ status until a ~~final eligibility~~ determination is
16 made on the individual's application for long-term care
17 services ~~approved or the applicant's appeal has been~~
18 ~~adjudicated and eligibility is denied~~. The Department or the
19 managed care organization, if applicable, must reimburse
20 providers for services rendered during an applicant's
21 provisional eligibility period.

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

26 (2) An applicant with provisional eligibility

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

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

20 (Source: P.A. 99-153, eff. 7-28-15; 100-380, eff. 8-25-17;
21 100-1141, eff. 11-28-18.)

22 (305 ILCS 5/12-4.42)

23 Sec. 12-4.42. Medicaid Revenue Maximization.

24 (a) Purpose. The General Assembly finds that there is a
25 need to make changes to the administration of services provided

1 by State and local governments in order to maximize federal
2 financial participation.

3 (b) Definitions. As used in this Section:

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

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

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

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

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

24 "Care provider for persons with a developmental
25 disability" means a person conducting, operating, or
26 maintaining a care facility for persons with a developmental

1 disability. For purposes of this definition, "person" means any
2 political subdivision of the State, municipal corporation,
3 individual, firm, partnership, corporation, company, limited
4 liability company, association, joint stock association, or
5 trust, or a receiver, executor, trustee, guardian, or other
6 representative appointed by order of any court.

7 "DHS" means the Illinois Department of Human Services.

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

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

26 "Long term care provider" means (i) a person licensed by

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

12 "State-operated facility for persons with a developmental
13 disability" means an intermediate care facility for persons
14 with an intellectual disability within the meaning of Title XIX
15 of the Social Security Act operated by the State.

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

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

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

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

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

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

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

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

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

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

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

25 (i) Acceleration of hospital-based payments. The
26 Department shall, by the 10th day of the month in which the

1 enhanced FMAP originally set forth in the ARRA expires, create
2 vouchers for all State fiscal year 2011 hospital payments
3 exempt from the prompt payment requirements of the ARRA. The
4 Department shall submit these vouchers to the Comptroller for
5 payment.

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

7 (305 ILCS 5/14-13 new)

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

10 (a) By October 1, 2019, the Department shall by rule
11 implement a methodology effective for dates of service July 1,
12 2019 and later to reimburse hospitals for inpatient stays
13 extended beyond medical necessity due to the inability of the
14 Department or the managed care organization in which a
15 recipient is enrolled or the hospital discharge planner to find
16 an appropriate placement after discharge from the hospital.

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

25 (c) The Department shall require managed care

1 organizations to adopt this methodology or an alternative
2 methodology that pays at least as much as the Department's
3 adopted methodology unless otherwise mutually agreed upon
4 contractual language is developed by the provider and the
5 managed care organization for a risk-based or innovative
6 payment methodology.

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

11 (e) For services covered by the fee-for-service program,
12 reimbursement under this Section shall only be made for days
13 beyond medical necessity that occur after the hospital has
14 notified the Department of the need for post-discharge
15 placement. For services covered by a managed care organization,
16 hospitals shall notify the appropriate managed care
17 organization of an admission within 24 hours of admission. For
18 every 24-hour period beyond the initial 24 hours after
19 admission that the hospital fails to notify the managed care
20 organization of the admission, reimbursement under this
21 subsection shall be reduced by one day.

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

24 (305 ILCS 5/5-5.07)

1 Sec. 5-5.07. Inpatient psychiatric stay; DCFS per diem
2 rate. The Department of Children and Family Services shall pay
3 the DCFS per diem rate for inpatient psychiatric stay at a
4 free-standing psychiatric hospital effective the 11th day when
5 a child is in the hospital beyond medical necessity, and the
6 parent or caregiver has denied the child access to the home and
7 has refused or failed to make provisions for another living
8 arrangement for the child or the child's discharge is being
9 delayed due to a pending inquiry or investigation by the
10 Department of Children and Family Services. If any portion of a
11 hospital stay is reimbursed under this Section, the hospital
12 stay shall not be eligible for payment under the provisions of
13 Section 14-13 of this Code. This Section is inoperative on and
14 after July 1, 2020. This Section is repealed 6 months after the
15 effective date of this amendatory Act of the 100th General
16 Assembly.

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

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