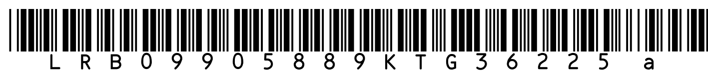
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Rep. Greg Harris

Filed: 5/27/2015

1 AMENDMENT TO SENATE BILL 788

2 AMENDMENT NO. ______. Amend Senate Bill 788 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. The Personnel Code is amended by changing
5 Section 4d as follows:

6 (20 ILCS 415/4d) (from Ch. 127, par. 63b104d)
7 Sec. 4d. Partial exemptions. The following positions in
8 State service are exempt from jurisdictions A, B, and C to the
9 extent stated for each, unless those jurisdictions are extended
10 as provided in this Act:
11 (1) In each department, board or commission that now
12 maintains or may hereafter maintain a major administrative
13 division, service or office in both Sangamon County and
14 Cook County, 2 private secretaries for the director or
15 chairman thereof, one located in the Cook County office and
16 the other located in the Sangamon County office, shall be

1 exempt from jurisdiction B; in all other departments,
2 boards and commissions one private secretary for the
3 director or chairman thereof shall be exempt from
4 jurisdiction B. In all departments, boards and commissions
5 one confidential assistant for the director or chairman
6 thereof shall be exempt from jurisdiction B. This paragraph
7 is subject to such modifications or waiver of the
8 exemptions as may be necessary to assure the continuity of
9 federal contributions in those agencies supported in whole
10 or in part by federal funds.
11 (2) The resident administrative head of each State
12 charitable, penal and correctional institution, the
13 chaplains thereof, and all member, patient and inmate
14 employees are exempt from jurisdiction B.
15 (3) The Civil Service Commission, upon written
16 recommendation of the Director of Central Management
17 Services, shall exempt from jurisdiction B other positions
18 which, in the judgment of the Commission, involve either
19 principal administrative responsibility for the
20 determination of policy or principal administrative
21 responsibility for the way in which policies are carried
22 out, except positions in agencies which receive federal
23 funds if such exemption is inconsistent with federal
24 requirements, and except positions in agencies supported
25 in whole by federal funds.
26 (4) All beauticians and teachers of beauty culture and

1 teachers of barbering, and all positions heretofore paid
2 under Section 1.22 of "An Act to standardize position
3 titles and salary rates", approved June 30, 1943, as
4 amended, shall be exempt from jurisdiction B.
5 (5) Licensed attorneys in positions as legal or
6 technical advisors, positions in the Department of Natural
7 Resources requiring incumbents to be either a registered
8 professional engineer or to hold a bachelor's degree in
9 engineering from a recognized college or university,
10 licensed physicians in positions of medical administrator
11 or physician or physician specialist (including
12 psychiatrists), all positions within the Department of
13 Juvenile Justice requiring licensure by the State Board of
14 Education under Article 21B of the School Code, and
15 registered nurses (except those registered nurses employed
16 by the Department of Public Health), except those in
17 positions in agencies which receive federal funds if such
18 exemption is inconsistent with federal requirements and
19 except those in positions in agencies supported in whole by
20 federal funds, are exempt from jurisdiction B only to the
21 extent that the requirements of Section 8b.1, 8b.3 and 8b.5
22 of this Code need not be met.
23 (6) All positions established outside the geographical
24 limits of the State of Illinois to which appointments of
25 other than Illinois citizens may be made are exempt from
26 jurisdiction B.

(7) Staff attorneys reporting directly to individual Commissioners of the Illinois Workers' Compensation Commission are exempt from jurisdiction B.

(8) Forty-six ~~Twenty-one~~ senior public service administrator positions within the Department of Healthcare and Family Services, as set forth in this paragraph (8), requiring the specific knowledge of healthcare administration, healthcare finance, healthcare data analytics, or information technology described are exempt from jurisdiction B only to the extent that the requirements of Sections 8b.1, 8b.3, and 8b.5 of this Code need not be met. The General Assembly finds that these positions are all senior policy makers and have spokesperson authority for the Director of the Department of Healthcare and Family Services. When filling positions so designated, the Director of Healthcare and Family Services shall cause a position description to be published which allots points to various qualifications desired. After scoring qualified applications, the Director shall add Veteran's Preference points as enumerated in Section 8b.7 of this Code. The following are the minimum qualifications for the senior public service administrator positions provided for in this paragraph (8):

(A) HEALTHCARE ADMINISTRATION.

Medical Director: Licensed Medical Doctor in good standing; experience in healthcare payment

1 systems, pay for performance initiatives, medical
2 necessity criteria or federal or State quality
3 improvement programs; preferred experience serving
4 Medicaid patients or experience in population
5 health programs with a large provider, health
6 insurer, government agency, or research
7 institution.
8 Chief, Bureau of Quality Management:
9 Bachelor's degree required, advanced ~~Advanced~~
10 degree in health policy or health professional
11 field preferred; at least 3 years experience in
12 implementing or managing healthcare quality
13 improvement initiatives in a clinical setting. At
14 least 3 years experience in managing and directing
15 staff. Excellent communications skills required.
16 Quality Management Bureau: Manager, Care
17 Coordination/Managed Care Quality: Clinical degree
18 or advanced degree in relevant field required;
19 experience in the field of managed care quality
20 improvement, with knowledge of HEDIS measurements,
21 coding, and related data definitions.
22 Quality Management Bureau: Manager, Primary
23 Care Provider Quality and Practice Development:
24 Clinical degree or advanced degree in relevant
25 field required; experience in practice
26 administration in the primary care setting with a

provider or a provider association or an accrediting body; knowledge of practice standards for medical homes and best evidence based standards of care for primary care.

Director of Care Coordination Contracts and Compliance: Bachelor's degree required; multi-year experience in negotiating managed care contracts, preferably on behalf of a payer; experience with health care contract compliance.

Manager, Long Term Care Policy: Bachelor's degree required; social work, gerontology, or social service degree preferred; knowledge of Olmstead and other relevant court decisions required; experience working with diverse long term care populations and service systems, federal initiatives to create long term care community options, and home and community-based waiver services required. The General Assembly finds that this position is necessary for the timely and effective implementation of this amendatory Act of the 97th General Assembly.

Manager, DD and Behavioral Health Integration ~~Programs~~:

Clinical license or Advanced degree required, preferably in psychology, social work, or relevant field; knowledge of medical necessity criteria and

governmental policies and regulations governing the provision of ~~mental health~~ services to Medicaid populations with dual diagnosis of developmental and behavioral disabilities~~,~~ ~~including children and adults,~~ in community and institutional settings of care. The General Assembly finds that this position is necessary for the timely and effective implementation of this amendatory Act of the 97th General Assembly.

Manager, Office of Accountable Care Entity Development: Bachelor's degree required, clinical degree or advanced degree in relevant field preferred; experience in developing integrated delivery systems, including knowledge of health homes and evidence-based standards of care delivery; multi-year experience in health care or public health management; knowledge of federal ACO or other similar delivery system requirements and strategies for improving health care delivery.

Manager of Federal Regulatory Compliance: Bachelor's degree required, advanced degree preferred, in healthcare management or relevant field; experience in healthcare administration or Medicaid State Plan amendments preferred; experience interpreting federal rules; experience with either federal health care agency or with a

State agency in working with federal regulations.

Director ~~Manager~~, Office of Medical Project Management: Bachelor's degree required, project management certification preferred; multi-year experience in project management and developing business analyst skills; leadership skills to manage multiple and complex projects.

Manager of Medicare/Medicaid Coordination: Bachelor's degree required, knowledge and experience with Medicare Advantage rules and regulations, knowledge of Medicaid laws and policies; experience with contract drafting preferred.

Chief, Bureau of Eligibility Integrity: Bachelor's degree required, advanced degree in public administration or business administration preferred; experience equivalent to 4 years of administration in a public or business organization required; experience with managing contract compliance required; knowledge of Medicaid eligibility laws and policy preferred; supervisory experience preferred. The General Assembly finds that this position is necessary for the timely and effective implementation of this amendatory Act of the 97th General Assembly.

Senior Coordinated Care Analyst: Bachelor's

1 degree required, preferably an advanced degree in
2 actuarial science, mathematics, or a related
3 analytic, statistics, or finance discipline. ASA
4 or FSA certification preferred; will consider
5 actuarial students or analysts. Requires prior
6 experience equivalent to at least 4 years of
7 healthcare cost analytics, including, but not
8 limited to: medical economics reporting or medical
9 cost action planning. Experience in Health
10 Insurance Portability and Accountability Act
11 (HIPAA) transactions relevant to health insurance
12 claim submissions, with preference for experience
13 specific to encounter claims. Preferred experience
14 with a health insurer or third party claims
15 administrator, a large provider, or other
16 knowledge of the healthcare claims system.
17 Chief, Bureau of Long Term Services and
18 Support: Bachelor's degree required, advanced
19 degree preferred, preferably in health care,
20 social work, psychology, business, or public
21 administration. Requires a minimum of 3 years of
22 experience in managing and directing staff;
23 knowledge of federal programs supporting the
24 growth of Medicaid-funded home and community-based
25 long term services and supports. Demonstrated
26 ability to interpret and translate federal and

1 State statutes, regulations, and policy. Requires
2 exceptional leadership and organizational skills.
3 Manager, Long Term Services and Supports
4 Performance Analysis: Bachelor's degree required,
5 advanced degree preferred, preferably in health
6 care, psychology, business, or public
7 administration. Requires knowledge of assessment
8 protocols utilized in Medicaid home and
9 community-based waiver programs. Requires
10 experience in analysis of long term care client
11 referral and transition trends. Requires
12 experience in preparing budgetary projections and
13 expenditure analysis. Requires exceptional oral
14 and written communication skills.
15 Chief, Bureau of Long Term Care: Bachelor's
16 degree required, advanced degree preferred,
17 preferably in health care, business, or public
18 administration. Requires at least 3 years
19 experience in managing and directing staff.
20 Requires knowledge of Medicaid-funded
21 institutional and home and community-based long
22 term services and supports. Demonstrated ability
23 to interpret and translate federal and State
24 statutes, regulations, and policy. Requires
25 exceptional leadership, communication, and
26 organizational skills.

Manager, Children's Behavioral Health Program: Clinical license or advanced degree required, preferably in psychology, social work, or relevant field. Requires knowledge of Medicaid, medical necessity standards, utilization review processes, and governmental policies and regulations governing the provision of behavioral health services to Medicaid and non-Medicaid eligible children. Requires knowledge of children's behavioral health settings ranging from community-based to institutional care and service modalities. Requires knowledge of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provision of the Medicaid statute for treatment of children's behavioral and emotional disorders. Requires knowledge and experience of Systems of Care principles including the use of care coordination and community integration.

Manager, Medical Programs Business Process Improvement: Requires Master's degree in Public Policy or Business Administration. Requires a minimum of 1 year of experience in health care administration. Requires experience analyzing complex business processes and developing solutions to improve efficiency and performance preferably in Medicaid or a related sector.

1 Requires strong written communication and
2 leadership skills.
3 Manager, Medicare/Medicaid Programs for Long
4 Term Services and Support Program: Bachelor's
5 degree required, advanced degree preferred,
6 preferably in health care, business, or public
7 administration. Requires a minimum of 2 years
8 healthcare administration experience, preferably
9 in Medicare, including knowledge of Medicare
10 Advantage or Medicare fee-for-service programs or
11 other managed care organizations. Requires
12 effective leadership and communication skills.
13 Manager, Medicare/Medicaid Alignment
14 Initiative (MMAI) Program: Bachelor's degree
15 required, advanced degree preferred, preferably in
16 health care, business, or public administration.
17 Requires a minimum of 2 years healthcare
18 administration experience, preferably in Medicare,
19 including knowledge of Medicare Advantage or
20 Medicare fee-for-service programs or other managed
21 care organizations. Requires effective leadership
22 and communication skills.
23 Manager, Managed Care Performance Analysis:
24 Bachelor's degree required, advanced degree
25 preferred, preferably in health care, business, or
26 public administration. Requires experience and

1 knowledge in the analysis of managed care
2 performance in providing health care and care
3 coordination. Requires knowledge of measurement
4 standards used in such analysis. Requires
5 leadership, communication, and decision making
6 skills.
7 Manager, Managed Care Contracting Process:
8 Bachelor's degree required, advanced degree
9 preferred, preferably in health care, business, or
10 public administration. Requires experience
11 developing programs, writing, and processing
12 contracts. Requires leadership skills and
13 exceptional organizational skills, including the
14 ability to develop projects and see them through to
15 completion.
16 Manager, Managed Care Deliverable Monitoring:
17 Bachelor's degree required, advanced degree
18 preferred, preferably in health care, accounting,
19 business, or public administration. Requires
20 experience analyzing and monitoring contract
21 deliverables to ensure requirements are met.
22 Requires experience working for or with managed
23 care organizations, leadership skills, and the
24 ability to effectively communicate with executive
25 level administrators of managed care
26 organizations.

1 Senior Project Managers, Office of Medical
2 Project Management (2 positions): Bachelor's
3 degree required, project management certification
4 preferred. Requires multi-year experience in
5 project management and developing business analyst
6 skills. Requires leadership and communications
7 skills to manage multiple and complex projects.
8 Director, Pharmacy Management: Bachelor's
9 degree required, advanced degree preferred,
10 preferably in pharmacy, health care, business, or
11 public administration. At least 2 years proven
12 experience in pharmacy field, preferably in
13 pharmacy benefits management.
14 Chief, Bureau of Professional and Ancillary
15 Services: Bachelor's degree required, advanced
16 degree preferred, preferably in health care,
17 business, or public administration. At least 2
18 years experience in health care or related
19 customer service field. At least 3 years
20 experience managing and directing staff. Preferred
21 experience managing utilization review or prior
22 approval processes and customer service.
23 Assistant Chief, Bureau of Eligibility
24 Integrity: Bachelor's degree required, advanced
25 degree in public or business administration
26 preferred. Requires experience equivalent to 4

years of administration in a public or business organization. Experience in communicating to people with low reading ability preferred. Knowledge of Medicaid eligibility laws and policy preferred. Supervisory experience preferred.

Senior Account Managers, Managed Care Implementation and Customer Service, 2 positions: Bachelor's degree required, advanced degree preferred. Ability to synthesize multiple information sets, ability to communicate well with senior "C suite" executives. Experience in health plan customer/provider service preferred.

Director of Medical Economics: Bachelor's degree required. MBA, Master's in Economics, or Actuarial degree preferred; 2 years experience in predictive modeling, including, but not limited to, identifying trends and outliers. Prefer 2 years experience in managing and directing small teams. Prefer experience in building a team to turn complex data sets into information and actionable items.

(B) HEALTHCARE FINANCE.

Deputy Administrator ~~Director~~ of Care Coordination ~~Rate and Finance~~: MBA, MPA or other advanced ~~CPA, or Actuarial~~ degree required; experience in managed care programs and care

coordination models ~~rate setting~~, including, but not limited to, managed care ~~baseline costs and growth~~ trends, high level contracting, monitoring and negotiation; knowledge and experience with Medical Loss Ratio standards and measurements. Requires at least 4 years experience team building, managing and directing staff.

Director of Encounter Data Program: Bachelor's degree required, advanced degree preferred, preferably in health care, business, or information systems; at least 2 years healthcare or other similar data reporting experience, including, but not limited to, data definitions, submission, and editing; background in HIPAA transactions relevant to encounter data submission; experience with large provider, health insurer, government agency, or research institution or other knowledge of healthcare claims systems.

Manager of Medical Finance, Division of Finance: Requires relevant advanced degree or certification in relevant field, such as Certified Public Accountant; coursework in business or public administration, accounting, finance, data analysis, or statistics preferred; experience in control systems and GAAP; financial management

1 experience in a healthcare or government entity
2 utilizing Medicaid funding.
3 (C) HEALTHCARE DATA ANALYTICS.
4 Data Quality Assurance Manager <u>(2 Positions)</u>:
5 Bachelor's degree required, advanced degree
6 preferred, preferably in business, information
7 systems, or epidemiology; at least 3 years of
8 extensive healthcare data reporting experience
9 with a large provider, health insurer, government
10 agency, or research institution; previous data
11 quality assurance role or formal data quality
12 assurance training.
13 Data Analytics Unit Manager <u>(2 Positions)</u>:
14 Bachelor's degree required, advanced degree
15 preferred, in information systems, applied
16 mathematics, or another field with a strong
17 analytics component; extensive healthcare data
18 reporting experience with a large provider, health
19 insurer, government agency, or research
20 institution; experience as a business analyst
21 interfacing between business and information
22 technology departments; in-depth knowledge of
23 health insurance coding and evolving healthcare
24 quality metrics; working knowledge of SQL and/or
25 SAS.
26 Data Analytics Platform Manager <u>(2 Positions)</u>:

1 Bachelor's degree required, advanced degree
2 preferred, preferably in business or information
3 systems; extensive healthcare data reporting
4 experience with a large provider, health insurer,
5 government agency, or research institution;
6 previous experience working on a health insurance
7 data analytics platform; experience managing
8 contracts and vendors preferred.
9 (D) HEALTHCARE INFORMATION TECHNOLOGY.
10 Manager of MMIS Claims Unit: Bachelor's degree
11 required, with preferred coursework in business,
12 public administration, information systems;
13 experience equivalent to 4 years of administration
14 in a public or business organization; working
15 knowledge with design and implementation of
16 technical solutions to medical claims payment
17 systems; extensive technical writing experience,
18 including, but not limited to, the development of
19 RFPs, APDs, feasibility studies, and related
20 documents; thorough knowledge of IT system design,
21 commercial off the shelf software packages and
22 hardware components.
23 Assistant Bureau Chief, Application
24 Development Office of Information Systems:
25 Bachelor's degree required, with preferred
26 coursework in business, public administration,

information systems; experience equivalent to 5 years of administration in a public or private business organization; extensive technical writing experience, including, but not limited to, the development of RFPs, APDs, feasibility studies and related documents; extensive healthcare technology experience with a large provider, health insurer, government agency, or research institution; experience as a business analyst interfacing between business and information technology departments; thorough knowledge of IT system design, commercial off the shelf software packages and hardware components.

Technical System Architect: Bachelor's degree required, with preferred coursework in computer science or information technology; prior experience equivalent to 5 years of computer science or IT administration in a public or business organization; extensive healthcare technology experience with a large provider, health insurer, government agency, or research institution; experience as a business analyst interfacing between business and information technology departments.

Chief, Bureau of Medicaid Management Information Systems: Bachelor's degree required,

with preferred coursework in business, public administration, information systems; working knowledge of a Medicaid Management Information System including Specialized Reporting, Third Party Liability and Recipient Benefits; extensive technical writing experience, including, but not limited to, the development of RFP's, APD's, feasibility studies, and related documents; thorough knowledge of IT system design.

Chief, Bureau of Administrative and Financial Operations: Bachelor's degree required, with preferred coursework in business, public administration, information system; experience equivalent to 4 years of administration in a public or business organization; extensive technical writing experience, including, but not limited to, the development of RFP's, APD's, feasibility studies, and related documents; thorough knowledge of IT system design; have experience in developing DIS budgets; working knowledge of financial system management, procurement, and accounting.

Section Manager of Project Management: Bachelor's degree required, with preferred coursework in business, public administration, information systems; experience equivalent to 4 years of administration in a public or business

organization; experience as a business analyst interfacing between business and information technology departments; thorough knowledge of IT system design; experience with directing and managing in-depth research and analysis on information technology projects; PMP certified and knowledge of the different Project Methodologies is a plus; extensive technical writing experience, including, but not limited to, the development of RFP's, APD's, feasibility studies, and related documents.

The provisions of this paragraph (8), other than this sentence, are inoperative after July 1, 2018 ~~January 1, 2014~~.

(Source: P.A. 97-649, eff. 12-30-11; 97-689, eff. 6-14-12; 98-104, eff. 7-22-13; 98-1146, eff. 12-30-14.)

Section 5. The Emergency Medical Services (EMS) Systems Act is amended by changing Section 32.5 as follows:

(210 ILCS 50/32.5)

Sec. 32.5. Freestanding Emergency Center.

(a) The Department shall issue an annual Freestanding Emergency Center (FEC) license to any facility that has received a permit from the Health Facilities and Services Review Board to establish a Freestanding Emergency Center by

1 January 1, 2015, and:
2 (1) is located: (A) in a municipality with a population
3 of 50,000 or fewer inhabitants; (B) within 50 miles of the
4 hospital that owns or controls the FEC; and (C) within 50
5 miles of the Resource Hospital affiliated with the FEC as
6 part of the EMS System;
7 (2) is wholly owned or controlled by an Associate or
8 Resource Hospital, but is not a part of the hospital's
9 physical plant;
10 (3) meets the standards for licensed FECs, adopted by
11 rule of the Department, including, but not limited to:
12 (A) facility design, specification, operation, and
13 maintenance standards;
14 (B) equipment standards; and
15 (C) the number and qualifications of emergency
16 medical personnel and other staff, which must include
17 at least one board certified emergency physician
18 present at the FEC 24 hours per day.
19 (4) limits its participation in the EMS System strictly
20 to receiving a limited number of BLS runs by emergency
21 medical vehicles according to protocols developed by the
22 Resource Hospital within the FEC's designated EMS System
23 and approved by the Project Medical Director and the
24 Department;
25 (5) provides comprehensive emergency treatment
26 services, as defined in the rules adopted by the Department

1 pursuant to the Hospital Licensing Act, 24 hours per day,
2 on an outpatient basis;
3 (6) provides an ambulance and maintains on site
4 ambulance services staffed with paramedics 24 hours per
5 day;
6 (7) (blank);
7 (8) complies with all State and federal patient rights
8 provisions, including, but not limited to, the Emergency
9 Medical Treatment Act and the federal Emergency Medical
10 Treatment and Active Labor Act;
11 (9) maintains a communications system that is fully
12 integrated with its Resource Hospital within the FEC's
13 designated EMS System;
14 (10) reports to the Department any patient transfers
15 from the FEC to a hospital within 48 hours of the transfer
16 plus any other data determined to be relevant by the
17 Department;
18 (11) submits to the Department, on a quarterly basis,
19 the FEC's morbidity and mortality rates for patients
20 treated at the FEC and other data determined to be relevant
21 by the Department;
22 (12) does not describe itself or hold itself out to the
23 general public as a full service hospital or hospital
24 emergency department in its advertising or marketing
25 activities;
26 (13) complies with any other rules adopted by the

1 Department under this Act that relate to FECs;
2 (14) passes the Department's site inspection for
3 compliance with the FEC requirements of this Act;
4 (15) submits a copy of the permit issued by the Health
5 Facilities and Services Review Board indicating that the
6 facility has complied with the Illinois Health Facilities
7 Planning Act with respect to the health services to be
8 provided at the facility;
9 (16) submits an application for designation as an FEC
10 in a manner and form prescribed by the Department by rule;
11 and
12 (17) pays the annual license fee as determined by the
13 Department by rule.
14 (a-5) Notwithstanding any other provision of this Section,
15 the Department may issue an annual FEC license to a facility
16 that is located in a county that does not have a licensed
17 general acute care hospital if the facility's application for a
18 permit from the Illinois Health Facilities Planning Board has
19 been deemed complete by the Department of Public Health by
20 January 1, 2014 and if the facility complies with the
21 requirements set forth in paragraphs (1) through (17) of
22 subsection (a).
23 (a-10) Notwithstanding any other provision of this
24 Section, the Department may issue an annual FEC license to a
25 facility if the facility has, by January 1, 2014, filed a
26 letter of intent to establish an FEC and if the facility

1 complies with the requirements set forth in paragraphs (1)
2 through (17) of subsection (a).
3 (a-15) Notwithstanding any other provision of this
4 Section, the Department shall issue an annual FEC license to a
5 facility located within a municipality with a population in
6 excess of 1,000,000 inhabitants if the facility (i) has, by
7 January 1, 2016, filed a letter of intent to establish an FEC,
8 (ii) has received a certificate of need from the Health
9 Facilities and Services Review Board, and (iii) complies with
10 all requirements set forth in paragraphs (3) through (17) of
11 subsection (a) of this Section and all applicable
12 administrative rules. Any FEC located in a municipality with a
13 population in excess of 1,000,000 inhabitants shall not be
14 required to be wholly owned or controlled by an Associate
15 Hospital or Resource Hospital; however, all patients needing
16 emergent or urgent evaluation or treatment beyond the FEC's
17 ability shall be expeditiously transferred to the closest
18 appropriate health care facility based on the patient's acuity
19 and needs. The FEC shall have a transfer agreement in place
20 with at least one acute care hospital in the FEC's service area
21 within 30 minutes travel time of the FEC. The medical director
22 of the FEC shall have full admitting privileges at a hospital
23 with which the FEC has a transfer agreement and shall agree in
24 writing to assume responsibility for all FEC patients requiring
25 follow-up care in accordance with the transfer agreement. For
26 an FEC established under this subsection (a-15), the facility

shall have the authority to create up to 10 observation beds as further defined by rule. The Department shall issue no more than one such license in a municipality with a population in excess of 1,000,000 inhabitants and shall give consideration to underserved areas, particularly those that have recently lost access to emergency care through the loss of an emergency care provider. An FEC qualifying under this subsection (a-15) shall fully participate with and function within a Department approved local EMS System.

(b) The Department shall:

(1) annually inspect facilities of initial FEC applicants and licensed FECs, and issue annual licenses to or annually relicense FECs that satisfy the Department's licensure requirements as set forth in subsection (a);

(2) suspend, revoke, refuse to issue, or refuse to renew the license of any FEC, after notice and an opportunity for a hearing, when the Department finds that the FEC has failed to comply with the standards and requirements of the Act or rules adopted by the Department under the Act;

(3) issue an Emergency Suspension Order for any FEC when the Director or his or her designee has determined that the continued operation of the FEC poses an immediate and serious danger to the public health, safety, and welfare. An opportunity for a hearing shall be promptly initiated after an Emergency Suspension Order has been

issued; and

(4) adopt rules as needed to implement this Section.

(Source: P.A. 96-23, eff. 6-30-09; 96-31, eff. 6-30-09; 96-883, eff. 3-1-10; 96-1000, eff. 7-2-10; 97-333, eff. 8-12-11; 97-1112, eff. 8-27-12.)

Section 15. The Illinois Public Aid Code is amended by changing Sections 5-5, 5-5.2, 5-30, 5A-2, 5A-12.2, 5A-12.5, 5A-13, 5G-10, 11-5.2, 11-5.4, 12-13.1, and 14-11 and by adding Sections 5-5b.1a, 5-5b.2, 5-30.2, 5-30.3, 5-30.4, 5-30.5, 12-4.49, and 12-4.50 as follows:

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

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

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

1 discover evidence which may be used in criminal proceedings
2 arising from the sexual assault; (16) the diagnosis and
3 treatment of sickle cell anemia; (16.5) services delivered by
4 facilities licensed under the Specialized Mental Health
5 Rehabilitation Act of 2013; and (17) any other medical care,
6 and any other type of remedial care recognized under the laws
7 of this State, but not including abortions, or induced
8 miscarriages or premature births, unless, in the opinion of a
9 physician, such procedures are necessary for the preservation
10 of the life of the woman seeking such treatment, or except an
11 induced premature birth intended to produce a live viable child
12 and such procedure is necessary for the health of the mother or
13 her unborn child. The Illinois Department, by rule, shall
14 prohibit any physician from providing medical assistance to
15 anyone eligible therefor under this Code where such physician
16 has been found guilty of performing an abortion procedure in a
17 wilful and wanton manner upon a woman who was not pregnant at
18 the time such abortion procedure was performed. The term "any
19 other type of remedial care" shall include nursing care and
20 nursing home service for persons who rely on treatment by
21 spiritual means alone through prayer for healing.

22 Notwithstanding any other provision of this Section, a
23 comprehensive tobacco use cessation program that includes
24 purchasing prescription drugs or prescription medical devices
25 approved by the Food and Drug Administration shall be covered
26 under the medical assistance program under this Article for

1 persons who are otherwise eligible for assistance under this
2 Article.

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

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

1 MCE's established rates or rate methodologies for eyeglasses.
2 On and after July 1, 2012, the Department of Healthcare and
3 Family Services may provide the following services to persons
4 eligible for assistance under this Article who are
5 participating in education, training or employment programs
6 operated by the Department of Human Services as successor to
7 the Department of Public Aid:
8 (1) dental services provided by or under the
9 supervision of a dentist; and
10 (2) eyeglasses prescribed by a physician skilled in the
11 diseases of the eye, or by an optometrist, whichever the
12 person may select.
13 Notwithstanding any other provision of this Code and
14 subject to federal approval, the Department may adopt rules to
15 allow a dentist who is volunteering his or her service at no
16 cost to render dental services through an enrolled
17 not-for-profit health clinic without the dentist personally
18 enrolling as a participating provider in the medical assistance
19 program. A not-for-profit health clinic shall include a public
20 health clinic or Federally Qualified Health Center or other
21 enrolled provider, as determined by the Department, through
22 which dental services covered under this Section are performed.
23 The Department shall establish a process for payment of claims
24 for reimbursement for covered dental services rendered under
25 this provision.
26 The Illinois Department, by rule, may distinguish and

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

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

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

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

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

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

24 (D) A comprehensive ultrasound screening of an entire
25 breast or breasts if a mammogram demonstrates
26 heterogeneous or dense breast tissue, when medically

1 necessary as determined by a physician licensed to practice
2 medicine in all of its branches.
3 All screenings shall include a physical breast exam,
4 instruction on self-examination and information regarding the
5 frequency of self-examination and its value as a preventative
6 tool. For purposes of this Section, "low-dose mammography"
7 means the x-ray examination of the breast using equipment
8 dedicated specifically for mammography, including the x-ray
9 tube, filter, compression device, and image receptor, with an
10 average radiation exposure delivery of less than one rad per
11 breast for 2 views of an average size breast. The term also
12 includes digital mammography.
13 On and after January 1, 2012, providers participating in a
14 quality improvement program approved by the Department shall be
15 reimbursed for screening and diagnostic mammography at the same
16 rate as the Medicare program's rates, including the increased
17 reimbursement for digital mammography.
18 The Department shall convene an expert panel including
19 representatives of hospitals, free-standing mammography
20 facilities, and doctors, including radiologists, to establish
21 quality standards.
22 Subject to federal approval, the Department shall
23 establish a rate methodology for mammography at federally
24 qualified health centers and other encounter-rate clinics.
25 These clinics or centers may also collaborate with other
26 hospital-based mammography facilities.

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 establish a performance goal for
6 primary care providers with respect to their female patients
7 over age 40 receiving an annual mammogram. This performance
8 goal shall be used to provide additional reimbursement in the
9 form of a quality performance bonus to primary care providers
10 who meet that goal.
11 The Department shall devise a means of case-managing or
12 patient navigation for beneficiaries diagnosed with breast
13 cancer. This program shall initially operate as a pilot program
14 in areas of the State with the highest incidence of mortality
15 related to breast cancer. At least one pilot program site shall
16 be in the metropolitan Chicago area and at least one site shall
17 be outside the metropolitan Chicago area. An evaluation of the
18 pilot program shall be carried out measuring health outcomes
19 and cost of care for those served by the pilot program compared
20 to similarly situated patients who are not served by the pilot
21 program.
22 Any medical or health care provider shall immediately
23 recommend, to any pregnant woman who is being provided prenatal
24 services and is suspected of drug abuse or is addicted as
25 defined in the Alcoholism and Other Drug Abuse and Dependency
26 Act, referral to a local substance abuse treatment provider

licensed by the Department of Human Services or to a licensed hospital which provides substance abuse treatment services. The Department of Healthcare and Family Services shall assure coverage for the cost of treatment of the drug abuse or addiction for pregnant recipients in accordance with the Illinois Medicaid Program in conjunction with the Department of Human Services.

All medical providers providing medical assistance to pregnant women under this Code shall receive information from the Department on the availability of services under the Drug Free Families with a Future or any comparable program providing case management services for addicted women, including information on appropriate referrals for other social services that may be needed by addicted women in addition to treatment for addiction.

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

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

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

10 The Illinois Department may develop and contract with
11 Partnerships of medical providers to arrange medical services
12 for persons eligible under Section 5-2 of this Code.
13 Implementation of this Section may be by demonstration projects
14 in certain geographic areas. The Partnership shall be
15 represented by a sponsor organization. The Department, by rule,
16 shall develop qualifications for sponsors of Partnerships.
17 Nothing in this Section shall be construed to require that the
18 sponsor organization be a medical organization.

19 The sponsor must negotiate formal written contracts with
20 medical providers for physician services, inpatient and
21 outpatient hospital care, home health services, treatment for
22 alcoholism and substance abuse, and other services determined
23 necessary by the Illinois Department by rule for delivery by
24 Partnerships. Physician services must include prenatal and
25 obstetrical care. The Illinois Department shall reimburse
26 medical services delivered by Partnership providers to clients

in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

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

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

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

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

Nothing in this Section shall limit the free choice of practitioners, hospitals, and other providers of medical services by clients. In order to ensure patient freedom of

choice, the Illinois Department shall immediately promulgate all rules and take all other necessary actions so that provided services may be accessed from therapeutically certified optometrists to the full extent of the Illinois Optometric Practice Act of 1987 without discriminating between service providers.

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons

1 eligible for medical assistance under this Code, in accordance
2 with regulations promulgated by the Illinois Department. The
3 rules and regulations shall require that proof of the receipt
4 of prescription drugs, dentures, prosthetic devices and
5 eyeglasses by eligible persons under this Section accompany
6 each claim for reimbursement submitted by the dispenser of such
7 medical services. No such claims for reimbursement shall be
8 approved for payment by the Illinois Department without such
9 proof of receipt, unless the Illinois Department shall have put
10 into effect and shall be operating a system of post-payment
11 audit and review which shall, on a sampling basis, be deemed
12 adequate by the Illinois Department to assure that such drugs,
13 dentures, prosthetic devices and eyeglasses for which payment
14 is being made are actually being received by eligible
15 recipients. Within 90 days after the effective date of this
16 amendatory Act of 1984, the Illinois Department shall establish
17 a current list of acquisition costs for all prosthetic devices
18 and any other items recognized as medical equipment and
19 supplies reimbursable under this Article and shall update such
20 list on a quarterly basis, except that the acquisition costs of
21 all prescription drugs shall be updated no less frequently than
22 every 30 days as required by Section 5-5.12.

23 The rules and regulations of the Illinois Department shall
24 require that a written statement including the required opinion
25 of a physician shall accompany any claim for reimbursement for
26 abortions, or induced miscarriages or premature births. This

statement shall indicate what procedures were used in providing such medical services.

Notwithstanding any other law to the contrary, the Illinois Department shall, by July 1, 2016, ~~within 365 days after July 22, 2013, (the effective date of Public Act 98-104),~~ establish procedures to permit skilled care facilities licensed under the Nursing Home Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

Notwithstanding any other law to the contrary, the Illinois Department shall, by July 1, 2016, ~~within 365 days after the effective date of this amendatory Act of the 98th General Assembly,~~ establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

The Illinois Department shall require all dispensers of medical services, other than an individual practitioner or group of practitioners, desiring to participate in the Medical Assistance program established under this Article to disclose

1 all financial, beneficial, ownership, equity, surety or other
2 interests in any and all firms, corporations, partnerships,
3 associations, business enterprises, joint ventures, agencies,
4 institutions or other legal entities providing any form of
5 health care services in this State under this Article.

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

14 Enrollment of a vendor shall be subject to a provisional
15 period and shall be conditional for one year. During the period
16 of conditional enrollment, the Department may terminate the
17 vendor's eligibility to participate in, or may disenroll the
18 vendor from, the medical assistance program without cause.
19 Unless otherwise specified, such termination of eligibility or
20 disenrollment is not subject to the Department's hearing
21 process. However, a disenrolled vendor may reapply without
22 penalty.

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

26 Prior to enrollment and during the conditional enrollment

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

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

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

medical goods or services were provided, with the following exceptions:

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

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

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

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

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

In the case of long term care facilities, within 5 days of

1 receipt by the facility of required prescreening information,
2 data for new admissions shall be entered into the Medical
3 Electronic Data Interchange (MEDI) or the Recipient
4 Eligibility Verification (REV) System or successor system, and
5 within 15 days of receipt by the facility of required
6 prescreening information, admission documents shall be
7 submitted through MEDI or REV or shall be submitted directly to
8 the Department of Human Services using required admission
9 forms. Effective September 1, 2014, admission documents,
10 including all prescreening information, must be submitted
11 through MEDI or REV. Confirmation numbers assigned to an
12 accepted transaction shall be retained by a facility to verify
13 timely submittal. Once an admission transaction has been
14 completed, all resubmitted claims following prior rejection
15 are subject to receipt no later than 180 days after the
16 admission transaction has been completed.

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

21 To the extent consistent with applicable information and
22 privacy, security, and disclosure laws, State and federal
23 agencies and departments shall provide the Illinois Department
24 access to confidential and other information and data necessary
25 to perform eligibility and payment verifications and other
26 Illinois Department functions. This includes, but is not

1 limited to: information pertaining to licensure;
2 certification; earnings; immigration status; citizenship; wage
3 reporting; unearned and earned income; pension income;
4 employment; supplemental security income; social security
5 numbers; National Provider Identifier (NPI) numbers; the
6 National Practitioner Data Bank (NPDB); program and agency
7 exclusions; taxpayer identification numbers; tax delinquency;
8 corporate information; and death records.

9 The Illinois Department shall enter into agreements with
10 State agencies and departments, and is authorized to enter into
11 agreements with federal agencies and departments, under which
12 such agencies and departments shall share data necessary for
13 medical assistance program integrity functions and oversight.
14 The Illinois Department shall develop, in cooperation with
15 other State departments and agencies, and in compliance with
16 applicable federal laws and regulations, appropriate and
17 effective methods to share such data. At a minimum, and to the
18 extent necessary to provide data sharing, the Illinois
19 Department shall enter into agreements with State agencies and
20 departments, and is authorized to enter into agreements with
21 federal agencies and departments, including but not limited to:
22 the Secretary of State; the Department of Revenue; the
23 Department of Public Health; the Department of Human Services;
24 and the Department of Financial and Professional Regulation.

25 Beginning in fiscal year 2013, the Illinois Department
26 shall set forth a request for information to identify the

1 benefits of a pre-payment, post-adjudication, and post-edit
2 claims system with the goals of streamlining claims processing
3 and provider reimbursement, reducing the number of pending or
4 rejected claims, and helping to ensure a more transparent
5 adjudication process through the utilization of: (i) provider
6 data verification and provider screening technology; and (ii)
7 clinical code editing; and (iii) pre-pay, pre- or
8 post-adjudicated predictive modeling with an integrated case
9 management system with link analysis. Such a request for
10 information shall not be considered as a request for proposal
11 or as an obligation on the part of the Illinois Department to
12 take any action or acquire any products or services.

13 The Illinois Department shall establish policies,
14 procedures, standards and criteria by rule for the acquisition,
15 repair and replacement of orthotic and prosthetic devices and
16 durable medical equipment. Such rules shall provide, but not be
17 limited to, the following services: (1) immediate repair or
18 replacement of such devices by recipients; and (2) rental,
19 lease, purchase or lease-purchase of durable medical equipment
20 in a cost-effective manner, taking into consideration the
21 recipient's medical prognosis, the extent of the recipient's
22 needs, and the requirements and costs for maintaining such
23 equipment. Subject to prior approval, such rules shall enable a
24 recipient to temporarily acquire and use alternative or
25 substitute devices or equipment pending repairs or
26 replacements of any device or equipment previously authorized

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

long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

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

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

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

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

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

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

1 The period covered by each report shall be the 3 years
2 ending on the June 30 prior to the report. The report shall
3 include suggested legislation for consideration by the General
4 Assembly. The filing of one copy of the report with the
5 Speaker, one copy with the Minority Leader and one copy with
6 the Clerk of the House of Representatives, one copy with the
7 President, one copy with the Minority Leader and one copy with
8 the Secretary of the Senate, one copy with the Legislative
9 Research Unit, and such additional copies with the State
10 Government Report Distribution Center for the General Assembly
11 as is required under paragraph (t) of Section 7 of the State
12 Library Act shall be deemed sufficient to comply with this
13 Section.

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

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

25 Because kidney transplantation can be an appropriate, cost
26 effective alternative to renal dialysis when medically

1 necessary and notwithstanding the provisions of Section 1-11 of
2 this Code, beginning October 1, 2014, the Department shall
3 cover kidney transplantation for noncitizens with end-stage
4 renal disease who are not eligible for comprehensive medical
5 benefits, who meet the residency requirements of Section 5-3 of
6 this Code, and who would otherwise meet the financial
7 requirements of the appropriate class of eligible persons under
8 Section 5-2 of this Code. To qualify for coverage of kidney
9 transplantation, such person must be receiving emergency renal
10 dialysis services covered by the Department for at least 2
11 years. Providers under this Section shall be prior approved and
12 certified by the Department to perform kidney transplantation
13 and the services under this Section shall be limited to
14 services associated with kidney transplantation.
15 (Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689,
16 eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section
17 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff.
18 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651,
19 eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14;
20 revised 10-2-14.)

21 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)
22 Sec. 5-5.2. Payment.
23 (a) All nursing facilities that are grouped pursuant to
24 Section 5-5.1 of this Act shall receive the same rate of
25 payment for similar services.

(b) It shall be a matter of State policy that the Illinois Department shall utilize a uniform billing cycle throughout the State for the long-term care providers.

(c) Notwithstanding any other provisions of this Code, the methodologies for reimbursement of nursing services as provided under this Article shall no longer be applicable for bills payable for nursing services rendered on or after a new reimbursement system based on the Resource Utilization Groups (RUGs) has been fully operationalized, which shall take effect for services provided on or after January 1, 2014.

(d) The new nursing services reimbursement methodology utilizing RUG-IV 48 grouper model, which shall be referred to as the RUGs reimbursement system, taking effect January 1, 2014, shall be based on the following:

(1) The methodology shall be resident-driven, facility-specific, and cost-based.

(2) Costs shall be annually rebased and case mix index quarterly updated. The nursing services methodology will be assigned to the Medicaid enrolled residents on record as of 30 days prior to the beginning of the rate period in the Department's Medicaid Management Information System (MMIS) as present on the last day of the second quarter preceding the rate period based upon the Assessment Reference Date of the Minimum Data Set (MDS).

(3) Regional wage adjustors based on the Health Service Areas (HSA) groupings and adjusters in effect on April 30,

1 2012 shall be included.
2 (4) Case mix index shall be assigned to each resident
3 class based on the Centers for Medicare and Medicaid
4 Services staff time measurement study in effect on July 1,
5 2013, utilizing an index maximization approach.
6 (5) The pool of funds available for distribution by
7 case mix and the base facility rate shall be determined
8 using the formula contained in subsection (d-1).
9 (d-1) Calculation of base year Statewide RUG-IV nursing
10 base per diem rate.
11 (1) Base rate spending pool shall be:
12 (A) The base year resident days which are
13 calculated by multiplying the number of Medicaid
14 residents in each nursing home as indicated in the MDS
15 data defined in paragraph (4) by 365.
16 (B) Each facility's nursing component per diem in
17 effect on July 1, 2012 shall be multiplied by
18 subsection (A).
19 (C) Thirteen million is added to the product of
20 subparagraph (A) and subparagraph (B) to adjust for the
21 exclusion of nursing homes defined in paragraph (5).
22 (2) For each nursing home with Medicaid residents as
23 indicated by the MDS data defined in paragraph (4),
24 weighted days adjusted for case mix and regional wage
25 adjustment shall be calculated. For each home this
26 calculation is the product of:

1 (A) Base year resident days as calculated in
2 subparagraph (A) of paragraph (1).
3 (B) The nursing home's regional wage adjustor
4 based on the Health Service Areas (HSA) groupings and
5 adjustors in effect on April 30, 2012.
6 (C) Facility weighted case mix which is the number
7 of Medicaid residents as indicated by the MDS data
8 defined in paragraph (4) multiplied by the associated
9 case weight for the RUG-IV 48 grouper model using
10 standard RUG-IV procedures for index maximization.
11 (D) The sum of the products calculated for each
12 nursing home in subparagraphs (A) through (C) above
13 shall be the base year case mix, rate adjusted weighted
14 days.
15 (3) The Statewide RUG-IV nursing base per diem rate:
16 (A) on January 1, 2014 shall be the quotient of the
17 paragraph (1) divided by the sum calculated under
18 subparagraph (D) of paragraph (2); and
19 (B) on and after July 1, 2014, shall be the amount
20 calculated under subparagraph (A) of this paragraph
21 (3) plus $1.76.
22 (4) Minimum Data Set (MDS) comprehensive assessments
23 for Medicaid residents on the last day of the quarter used
24 to establish the base rate.
25 (5) Nursing facilities designated as of July 1, 2012 by
26 the Department as "Institutions for Mental Disease" shall

be excluded from all calculations under this subsection. The data from these facilities shall not be used in the computations described in paragraphs (1) through (4) above to establish the base rate.

(e) Beginning July 1, 2014, the Department shall allocate funding in the amount up to $10,000,000 for per diem add-ons to the RUGS methodology for dates of service on and after July 1, 2014:

(1) $0.63 for each resident who scores in I4200 Alzheimer's Disease or I4800 non-Alzheimer's Dementia.

(2) $2.67 for each resident who scores either a "1" or "2" in any items S1200A through S1200I and also scores in RUG groups PA1, PA2, BA1, or BA2.

(e-1) (Blank).

(e-2) For dates of services beginning January 1, 2014, the RUG-IV nursing component per diem for a nursing home shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index, and the regional wage adjustor. Transition rates for services provided between January 1, 2014 and December 31, 2014 shall be as follows:

(1) The transition RUG-IV per diem nursing rate for nursing homes whose rate calculated in this subsection (e-2) is greater than the nursing component rate in effect July 1, 2012 shall be paid the sum of:

(A) The nursing component rate in effect July 1, 2012; plus

1 (B) The difference of the RUG-IV nursing component
2 per diem calculated for the current quarter minus the
3 nursing component rate in effect July 1, 2012
4 multiplied by 0.88.
5 (2) The transition RUG-IV per diem nursing rate for
6 nursing homes whose rate calculated in this subsection
7 (e-2) is less than the nursing component rate in effect
8 July 1, 2012 shall be paid the sum of:
9 (A) The nursing component rate in effect July 1,
10 2012; plus
11 (B) The difference of the RUG-IV nursing component
12 per diem calculated for the current quarter minus the
13 nursing component rate in effect July 1, 2012
14 multiplied by 0.13.
15 (f) Notwithstanding any other provision of this Code, on
16 and after July 1, 2012, reimbursement rates associated with the
17 nursing or support components of the current nursing facility
18 rate methodology shall not increase beyond the level effective
19 May 1, 2011 until a new reimbursement system based on the RUGs
20 IV 48 grouper model has been fully operationalized.
21 (g) Notwithstanding any other provision of this Code, on
22 and after July 1, 2012, for facilities not designated by the
23 Department of Healthcare and Family Services as "Institutions
24 for Mental Disease", rates effective May 1, 2011 shall be
25 adjusted as follows:
26 (1) Individual nursing rates for residents classified

1 in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter
2 ending March 31, 2012 shall be reduced by 10%;
3 (2) Individual nursing rates for residents classified
4 in all other RUG IV groups shall be reduced by 1.0%;
5 (3) Facility rates for the capital and support
6 components shall be reduced by 1.7%.
7 (h) Notwithstanding any other provision of this Code, on
8 and after July 1, 2012, nursing facilities designated by the
9 Department of Healthcare and Family Services as "Institutions
10 for Mental Disease" and "Institutions for Mental Disease" that
11 are facilities licensed under the Specialized Mental Health
12 Rehabilitation Act of 2013 shall have the nursing,
13 socio-developmental, capital, and support components of their
14 reimbursement rate effective May 1, 2011 reduced in total by
15 2.7%.
16 (i) On and after July 1, 2014, the reimbursement rates for
17 the support component of the nursing facility rate for
18 facilities licensed under the Nursing Home Care Act as skilled
19 or intermediate care facilities shall be the rate in effect on
20 June 30, 2014 increased by 8.17%.
21 (j) The Department may contract with a third-party auditor
22 to perform auditing to determine the accuracy of resident
23 assessment information transmitted in the MDS that is relevant
24 to the determination of reimbursement rates.
25 (Source: P.A. 97-689, eff. 6-14-12; 98-104, Article 6, Section
26 6-240, eff. 7-22-13; 98-104, Article 11, Section 11-35, eff.

7-22-13; 98-651, eff. 6-16-14; 98-727, eff. 7-16-14; 98-756, eff. 7-16-14; revised 10-2-14.)

(305 ILCS 5/5-5b.1a new)

Sec. 5-5b.1a. Pharmacy services; dispensing fees. For pharmacy services limited to the dispensing fees reduced in State fiscal year 2015 under Section 5-5b.1, the dispensing fees in State fiscal year 2016 shall be $2.35 for brand name drugs and $5.38 for generic drugs. Reimbursement methodology for product shall not be reduced as a result of this Section. This Section does not prevent the Department from making customary adjustments to pharmacy product prices for the State's Maximum Allowable Cost list for generic prescription medicines.

(305 ILCS 5/5-5b.2 new)

Sec. 5-5b.2. Reimbursement rates; fiscal year 2016 reductions.

(a) Except as provided in subsections (b) and (b-1), notwithstanding any other provision of this Code to the contrary, and subject to rescission if not federally approved, providers of the following services shall have their reimbursement rates or dispensing fees reduced for State fiscal year 2016. For each provider class, the Department must calculate a rate reduction which produces for each service type a total reduction in State fiscal year 2016 no greater than an

amount equal to the product of 2.25% multiplied by the originally enacted State fiscal year 2015 appropriations from the General Revenue Fund for each medical service type. The Department must only use appropriations from the General Revenue Fund to calculate the rate reduction amount for each service type. The rate reduction shall be applied equally to all services within the service type regardless of the fund from which payment is made. Medical services subject to rate reduction in State fiscal year 2016 are the following:

(1) Nursing facility services delivered by a nursing facility licensed under the Nursing Home Care Act.

(2) Home health services.

(3) Services delivered by a supportive living facility as defined in Section 5-5.01a.

(4) Services delivered by a specialized mental health rehabilitation facility licensed under the Specialized Mental Health Rehabilitation Act of 2013.

(5) Medical transportation services, including services delivered by a hospital, provided by (i) emergency and non-emergency ground and air ambulance, (ii) medi-car, (iii) service car, and (iv) taxi cab.

(6) Capitation payment rates to managed care entities shall include all reductions for those services as provided in this Section, as well as reductions in the administrative portion of the capitation rate. All reductions shall be made in an actuarially sound manner.

1 (7) Services for the treatment of hemophilia.
2 (8) Physician services.
3 (9) Dental services.
4 (10) Optometric services.
5 (11) Podiatry services.
6 (12) Laboratory services or services provided by
7 independent laboratories.
8 (13) Durable medical equipment and supplies.
9 (14) Renal dialysis services.
10 (15) Birth Center Services.
11 (16) Emergency services other than those offered by or
12 in a hospital.
13 (b) No provider shall be exempt from the rate reductions
14 authorized under this Section, except that rates or payments,
15 or the portion thereof, paid for private duty nursing services
16 or paid to a provider that is operated by a unit of government
17 that provides the non-federal share of such services shall not
18 be reduced as provided in this Section.
19 (b-1) The Department shall develop a State fiscal year 2016
20 blended rate for nursing services provided by facilities
21 licensed under the Nursing Home Care Act that takes into
22 account the State fiscal year 2016 appropriation from the
23 Long-Term Care Provider Fund and the adjusted State fiscal year
24 2016 appropriation for nursing services from the General
25 Revenue Fund. The State fiscal year 2016 blended rate shall
26 produce a savings to the State for fiscal year 2016 no greater

than an amount equal to the product of 2.25% multiplied by the originally enacted State fiscal year 2015 appropriations from the General Revenue Fund for nursing services. The State fiscal year 2016 blended rate shall be applied to all nursing services regardless of the source from which payment is made.

(c) For any rates which the Department cannot reduce due to federal law, court order, or specific statutory exemptions, the Department must identify the sum of reductions which cannot be attained. The sum must be proportionally distributed and added into the originally enacted State fiscal year 2015 appropriations from the General Revenue Fund for each medical service type prior to the calculation of the rate reduction specified in subsection (a). The Department may not redistribute reductions in any other manner.

The reductions required under this Section must be applied uniformly to all providers who deliver the same medical service type.

(d) In order to provide for the expeditious and timely implementation of the provisions of this Section, the Department shall adopt rules and may adopt emergency rules in accordance with subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act.

(305 ILCS 5/5-30)

Sec. 5-30. Care coordination.

(a) At least 50% of recipients eligible for comprehensive

1 medical benefits in all medical assistance programs or other
2 health benefit programs administered by the Department,
3 including the Children's Health Insurance Program Act and the
4 Covering ALL KIDS Health Insurance Act, shall be enrolled in a
5 care coordination program by no later than January 1, 2015. For
6 purposes of this Section, "coordinated care" or "care
7 coordination" means delivery systems where recipients will
8 receive their care from providers who participate under
9 contract in integrated delivery systems that are responsible
10 for providing or arranging the majority of care, including
11 primary care physician services, referrals from primary care
12 physicians, diagnostic and treatment services, behavioral
13 health services, in-patient and outpatient hospital services,
14 dental services, and rehabilitation and long-term care
15 services. The Department shall designate or contract for such
16 integrated delivery systems (i) to ensure enrollees have a
17 choice of systems and of primary care providers within such
18 systems; (ii) to ensure that enrollees receive quality care in
19 a culturally and linguistically appropriate manner; and (iii)
20 to ensure that coordinated care programs meet the diverse needs
21 of enrollees with developmental, mental health, physical, and
22 age-related disabilities.

23 (b) Payment for such coordinated care shall be based on
24 arrangements where the State pays for performance related to
25 health care outcomes, the use of evidence-based practices, the
26 use of primary care delivered through comprehensive medical

1 homes, the use of electronic medical records, and the
2 appropriate exchange of health information electronically made
3 either on a capitated basis in which a fixed monthly premium
4 per recipient is paid and full financial risk is assumed for
5 the delivery of services, or through other risk-based payment
6 arrangements.
7 (c) To qualify for compliance with this Section, the 50%
8 goal shall be achieved by enrolling medical assistance
9 enrollees from each medical assistance enrollment category,
10 including parents, children, seniors, and people with
11 disabilities to the extent that current State Medicaid payment
12 laws would not limit federal matching funds for recipients in
13 care coordination programs. In addition, services must be more
14 comprehensively defined and more risk shall be assumed than in
15 the Department's primary care case management program as of the
16 effective date of this amendatory Act of the 96th General
17 Assembly.
18 (d) The Department shall report to the General Assembly in
19 a separate part of its annual medical assistance program
20 report, beginning April, 2012 until April, 2016, on the
21 progress and implementation of the care coordination program
22 initiatives established by the provisions of this amendatory
23 Act of the 96th General Assembly. The Department shall include
24 in its April 2011 report a full analysis of federal laws or
25 regulations regarding upper payment limitations to providers
26 and the necessary revisions or adjustments in rate

methodologies and payments to providers under this Code that would be necessary to implement coordinated care with full financial risk by a party other than the Department.

(e) Integrated Care Program for individuals with chronic mental health conditions.

(1) The Integrated Care Program shall encompass services administered to recipients of medical assistance under this Article to prevent exacerbations and complications using cost-effective, evidence-based practice guidelines and mental health management strategies.

(2) The Department may utilize and expand upon existing contractual arrangements with integrated care plans under the Integrated Care Program for providing the coordinated care provisions of this Section.

(3) Payment for such coordinated care shall be based on arrangements where the State pays for performance related to mental health outcomes on a capitated basis in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements such as provider-based care coordination.

(4) The Department shall examine whether chronic mental health management programs and services for recipients with specific chronic mental health conditions do any or all of the following:

(A) Improve the patient's overall mental health in a more expeditious and cost-effective manner.

(B) Lower costs in other aspects of the medical assistance program, such as hospital admissions, emergency room visits, or more frequent and inappropriate psychotropic drug use.

(5) The Department shall work with the facilities and any integrated care plan participating in the program to identify and correct barriers to the successful implementation of this subsection (e) prior to and during the implementation to best facilitate the goals and objectives of this subsection (e).

(f) A hospital that is located in a county of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the county to enroll in a Care Coordination Program, as set forth in Section 5-30 of this Code, shall not be eligible for any non-claims based payments not mandated by Article V-A of this Code for which it would otherwise be qualified to receive, unless the hospital is a Coordinated Care Participating Hospital no later than 60 days after the effective date of this amendatory Act of the 97th General Assembly or 60 days after the first mandatory enrollment of a beneficiary in a Coordinated Care program. For purposes of this subsection, "Coordinated Care Participating Hospital" means a hospital that meets one of the following criteria:

(1) The hospital has entered into a contract to provide hospital services with one or more MCOs to enrollees of the care coordination program.

(2) The hospital has not been offered a contract by a care coordination plan that the Department has determined to be a good faith offer and that pays at least as much as the Department would pay, on a fee-for-service basis, not including disproportionate share hospital adjustment payments or any other supplemental adjustment or add-on payment to the base fee-for-service rate, except to the extent such adjustments or add-on payments are incorporated into the development of the applicable MCO capitated rates.

As used in this subsection (f), "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

(g) No later than August 1, 2013, the Department shall issue a purchase of care solicitation for Accountable Care Entities (ACE) to serve any children and parents or caretaker relatives of children eligible for medical assistance under this Article. An ACE may be a single corporate structure or a network of providers organized through contractual relationships with a single corporate entity. The solicitation shall require that:

(1) An ACE operating in Cook County be capable of serving at least 40,000 eligible individuals in that

county; an ACE operating in Lake, Kane, DuPage, or Will Counties be capable of serving at least 20,000 eligible individuals in those counties and an ACE operating in other regions of the State be capable of serving at least 10,000 eligible individuals in the region in which it operates. During initial periods of mandatory enrollment, the Department shall require its enrollment services contractor to use a default assignment algorithm that ensures if possible an ACE reaches the minimum enrollment levels set forth in this paragraph.

(2) An ACE must include at a minimum the following types of providers: primary care, specialty care, hospitals, and behavioral healthcare.

(3) An ACE shall have a governance structure that includes the major components of the health care delivery system, including one representative from each of the groups listed in paragraph (2).

(4) An ACE must be an integrated delivery system, including a network able to provide the full range of services needed by Medicaid beneficiaries and system capacity to securely pass clinical information across participating entities and to aggregate and analyze that data in order to coordinate care.

(5) An ACE must be capable of providing both care coordination and complex case management, as necessary, to beneficiaries. To be responsive to the solicitation, a

potential ACE must outline its care coordination and complex case management model and plan to reduce the cost of care.

(6) In the first 18 months of operation, unless the ACE selects a shorter period, an ACE shall be paid care coordination fees on a per member per month basis that are projected to be cost neutral to the State during the term of their payment and, subject to federal approval, be eligible to share in additional savings generated by their care coordination. For ACEs with a contract with the Department as of January 1, 2015, their 18 month period of operation shall begin on January 1, 2015 and the Department shall pay a care coordination fee on a per member per month basis at a rate no less than the amount paid as of January 1, 2015. Nothing in this provision prohibits the following: (i) an ACE from partnering with another managed care entity, (ii) an ACE from moving to capitation sooner than the aforementioned timelines, and (iii) the Department from sanctioning or terminating an ACE for substantive contractual violations.

(7) In months 19 through 36 of operation, unless the ACE selects a shorter period, an ACE shall be paid on a pre-paid capitation basis for all medical assistance covered services, under contract terms similar to Managed Care Organizations (MCO), with the Department sharing the risk through either stop-loss insurance for extremely high

1 cost individuals or corridors of shared risk based on the
2 overall cost of the total enrollment in the ACE. The ACE
3 shall be responsible for claims processing, encounter data
4 submission, utilization control, and quality assurance.
5 The Department shall evaluate the ACE readiness to accept
6 capitation. The readiness review shall utilize written
7 criteria that are shared with the ACEs and shall be
8 completed 3 months prior to initiation of capitation
9 payments. The Department shall establish by rule an appeals
10 process for any ACE that has not met the Department's
11 criteria for accepting capitation payments.
12 (8) In the fourth and subsequent years of operation, an
13 ACE shall convert to a Managed Care Community Network
14 (MCCN), as defined in this Article, or Health Maintenance
15 Organization pursuant to the Illinois Insurance Code,
16 accepting full-risk capitation payments.
17 The Department shall allow potential ACE entities 5 months
18 from the date of the posting of the solicitation to submit
19 proposals. After the solicitation is released, in addition to
20 the MCO rate development data available on the Department's
21 website, subject to federal and State confidentiality and
22 privacy laws and regulations, the Department shall provide 2
23 years of de-identified summary service data on the targeted
24 population, split between children and adults, showing the
25 historical type and volume of services received and the cost of
26 those services to those potential bidders that sign a data use

1 agreement. The Department may add up to 2 non-state government
2 employees with expertise in creating integrated delivery
3 systems to its review team for the purchase of care
4 solicitation described in this subsection. Any such
5 individuals must sign a no-conflict disclosure and
6 confidentiality agreement and agree to act in accordance with
7 all applicable State laws.

8 During the first 2 years of an ACE's operation, the
9 Department shall provide claims data to the ACE on its
10 enrollees on a periodic basis no less frequently than monthly.

11 Nothing in this subsection shall be construed to limit the
12 Department's mandate to enroll 50% of its beneficiaries into
13 care coordination systems by January 1, 2015, using all
14 available care coordination delivery systems, including Care
15 Coordination Entities (CCE), MCCNs, or MCOs, nor be construed
16 to affect the current CCEs, MCCNs, and MCOs selected to serve
17 seniors and persons with disabilities prior to that date.

18 Nothing in this subsection precludes the Department from
19 considering future proposals for new ACEs or expansion of
20 existing ACEs at the discretion of the Department.

21 (h) Department contracts with MCOs and other entities
22 reimbursed by risk based capitation shall have a minimum
23 medical loss ratio of 85%, shall require the entity to
24 establish an appeals and grievances process for consumers and
25 providers, and shall require the entity to provide a quality
26 assurance and utilization review program. Entities contracted

1 with the Department to coordinate healthcare regardless of risk
2 shall be measured utilizing the same quality metrics. The
3 quality metrics may be population specific. Any contracted
4 entity serving at least 5,000 seniors or people with
5 disabilities or 15,000 individuals in other populations
6 covered by the Medical Assistance Program that has been
7 receiving full-risk capitation for a year shall be accredited
8 by a national accreditation organization authorized by the
9 Department within 2 years after the date it is eligible to
10 become accredited. The requirements of this subsection shall
11 apply to contracts with MCOs entered into or renewed or
12 extended after June 1, 2013.

13 (h-5) The Department shall monitor and enforce compliance
14 by MCOs with agreements they have entered into with providers
15 on issues that include, but are not limited to, timeliness of
16 payment, payment rates, and processes for obtaining prior
17 approval. The Department may impose sanctions on MCOs for
18 violating provisions of those agreements that include, but are
19 not limited to, financial penalties, suspension of enrollment
20 of new enrollees, and termination of the MCO's contract with
21 the Department. As used in this subsection (h-5), "MCO" has the
22 meaning ascribed to that term in Section 5-30.1 of this Code.

23 (i) As used in this subsection:

24 "Care coordination entity" means a collaboration of
25 providers and community agencies, governed by a lead entity,
26 which receives a care coordination payment with a portion of

the payment at risk for meeting quality outcome targets in order to provide care coordination services for its enrollees.

"CCE" means either a care coordination entity or a pediatric care coordination entity.

"Children with complex medical needs" means persons under 21 years of age who are clients of medical assistance programs or other health benefit programs administered by the Department through the use of the 3M™ Clinical Risk Grouping Software (CRG) as Status 6.1 and above, through a clinical screening tool, or those who do not have sufficient claims data in order to be identified by the Department through the CRG software.

"Pediatric care coordination entity" means a collaboration of providers and community agencies, governed by a lead entity, serving primarily persons under 21 years of age which receives a care coordination payment with a portion of the payment at risk for meeting quality outcome targets in order to provide care coordination services for its enrollees.

"Pediatric care coordination plan" means a pediatric care coordination entity defined in this subsection or a pediatric-only managed care community network as defined in subsection (b) of Section 5-11.

Beginning on the effective date of this amendatory Act of the 99th General Assembly and until April 1, 2016, the Department, where available, shall offer newly eligible children with complex medical needs and currently eligible children with complex medical needs making their annual health

plan choice the choice of enrollment in a pediatric care coordination entity as defined in this subsection. At any time, the Department may offer, where available, the choice of enrollment in a pediatric-only managed care community network as defined in subsection (b) of Section 5-11. On and after April 1, 2016, the Department shall offer a pediatric care coordination plan, where available, but may require the plan to meet the requirements of subsection (b) of Section 5-11. This choice shall be in addition to otherwise available health maintenance organizations (HMOs), managed care community networks (MCCNs), and accountable care entities (ACEs).

Children with complex medical needs under 18 years of age shall be eligible to enroll in the pediatric care coordination plan as long as such children continue to maintain eligibility for medical assistance programs or other health benefit programs administered by the Department. The Department may choose to extend enrollment to individuals under 21 years of age for initial enrollment. Individuals may also be excluded if they are:

(1) enrolled in the Medically Fragile Technology Dependent Waiver;

(2) receiving private duty nursing;

(3) eligible for high third-party liability coverage as defined by the Department;

(4) residing in institutions, including pediatric skilled nursing facilities;

1 (5) enrolled in the DSCC Core Program; or
2 (6) placed in foster care with the Department of
3 Children and Family Services.
4 The Department shall ensure that the parents of all
5 eligible enrollees that are children with complex medical needs
6 shall receive notification of their eligibility and an
7 explanation of how to elect the pediatric care coordination
8 plan option. The Department shall ensure that any third-party
9 enrollment broker is briefed on the pediatric care coordination
10 plan option and that the broker shall ensure that all
11 enrollment options are presented to the parents of children
12 with complex medical needs.
13 The Department shall provide care coordination fees for
14 care coordination entities for seniors and persons with
15 disabilities and for pediatric care coordination entities for
16 children with complex medical needs, except for a pediatric
17 care coordination entity that had at least 1,500 enrollees as
18 of March 1, 2015, for a period of at least 36 months of
19 operation at a per member per month rate no less than the
20 schedule of rates in effect as of January 1, 2015, or as agreed
21 to by the CCE. The Department shall provide care coordination
22 fees for pediatric care coordination entities for children with
23 complex medical needs that had at least 1,500 enrollees as of
24 March 1, 2015, until April 1, 2016, at a per member per month
25 rate no less than the schedule of rates in effect as of January
26 1, 2015, or as agreed to by the CCE. After 24 months of

1 operation, but before 36 months, the Department shall evaluate
2 each CCE's performance in the areas of care coordination,
3 clinical integration, quality measurement performance,
4 including health care utilization, and health care
5 expenditures. For purposes of this Section, a CCE's date of
6 operation shall be the month when care coordination payments
7 were first paid. Nothing in this provision prohibits the
8 following: (i) a CCE from partnering with another managed care
9 entity, (ii) a CCE from moving to capitation sooner than the
10 aforementioned timelines, and (iii) the Department from
11 sanctioning or terminating a CCE for substantive contractual
12 violations.
13 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13;
14 98-651, eff. 6-16-14.)

15 (305 ILCS 5/5-30.2 new)
16 Sec. 5-30.2. Managed care; automatic assignment. The
17 Department shall, within a reasonable period of time after
18 relevant data from managed care entities has been collected and
19 analyzed, but no earlier than January 1, 2017, develop and
20 implement within each enrollment region an algorithm that takes
21 into account quality scores and other operational proficiency
22 criteria developed, defined, and adopted by the Department, to
23 automatically assign Medicaid enrollees served under the
24 Family Health Plan and the Integrated Care Program and those
25 Medicaid enrollees eligible for medical assistance pursuant to

1 the Patient Protection and Affordable Care Act (Public Law
2 111-148) into managed care entities, including Accountable
3 Care Entities, Managed Care Community Networks, and Managed
4 Care Organizations. The quality metrics used shall be
5 measurable for all entities. The algorithm shall not use the
6 quality and proficiency metrics to reassign enrollees out of
7 any plan that they are enrolled with at the time and shall only
8 be used if the client has not voluntarily selected a primary
9 care physician and a managed care entity or care coordination
10 entity. Clients shall have one opportunity within 90 calendar
11 days after auto assignment by algorithm to select a different
12 managed care entity. The algorithm developed and implemented
13 shall favor assignment into managed care entities with the
14 highest quality scores and levels of compliance with the
15 operational proficiency criteria established.

16 (305 ILCS 5/5-30.3 new)
17 Sec. 5-30.3. Managed care; wards of the Department of
18 Children and Family Services. The Department shall seek a
19 waiver from the federal Centers for Medicare and Medicaid
20 Services to allow mandatory enrollment of wards of the
21 Department of Children and Family Services into Medicaid
22 managed care and care coordination plans. The Department must
23 submit a waiver request to the federal Centers for Medicare and
24 Medicaid Services no later than October 1, 2015 and shall take
25 all necessary actions to obtain approval, including appeal of

1 any denial. Beginning January 1, 2016, the Department shall
2 report progress on the waiver required under this Section and
3 shall report quarterly until the waiver request is approved or
4 denied. Upon federal approval, the Department shall develop a
5 process to ensure that all wards of the Department of Children
6 and Family Services are enrolled in Medicaid managed care and
7 care coordination plans.

8 (305 ILCS 5/5-30.4 new)
9 Sec. 5-30.4. Managed care capitated rates; specialized
10 mental health rehabilitation facilities. Services delivered by
11 facilities licensed under the Specialized Mental Health
12 Rehabilitation Act of 2013 shall be a covered Medicaid service
13 for eligible Medicaid enrollees under both fee-for-service,
14 managed care, and care-coordination arrangements. The
15 Department shall ensure that all residents of facilities
16 licensed under the Specialized Mental Health Rehabilitation
17 Act of 2013 who are eligible for Medicaid are enrolled in
18 Medicaid managed care.

19 (305 ILCS 5/5-30.5 new)
20 Sec. 5-30.5. Managed care policy manual.
21 (a) The Department by January 1, 2016 must make available
22 on its website a managed care policy manual for providers. The
23 manual must be updated no less than annually, but may be
24 updated no more frequently than monthly and no changes shall be

1 effective until at least 30 days after the publication of the
2 change in the manual. The manual and updates shall be developed
3 and issued only after the Department has consulted with
4 representatives of providers and managed care entities,
5 including the Statewide associations representing such
6 stakeholders. Manuals posted pursuant to this Section shall be
7 consistent with the Managed Care Reform and Patient Rights Act,
8 the Health Maintenance Organization Act, and the
9 Medicare-Medicaid Alignment Initiative (MMAI) Nursing Home
10 Residents' Managed Care Rights Law, as applicable.
11 (b) The Department may post separate manuals based on the
12 population served by the managed care coverage plan, such as
13 seniors and people with disabilities. The Department must
14 clearly distinguish any differences in information based on the
15 managed care coverage plans.
16 (c) The manual must include no less than the following
17 information: (i) the process for providers to appeal payment
18 decisions made by the managed care plan, (ii) the process for
19 enrollees to appeal decisions made by managed care entities,
20 (iii) electronic links to information required for obtaining
21 approval for services by each plan, (iv) the contact
22 information for either a provider or an enrollee to file a
23 complaint with the Department about a managed care plan, (v)
24 the Department's requirements for each plan to provide services
25 and timeliness of payment, (vi) all timeframes for each plan to
26 approve or deny coverage, (vii) an electronic link to the

1 information on identifying all the providers currently
2 providing services for a managed care plan, (viii) the process
3 and contact information for an enrollee to change managed care
4 plans, (ix) contact information for an enrollee to change a
5 primary care physician or correct personal information, and (x)
6 contact information for each plan for provider relations and
7 customer service concerns.

8 (305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)
9 (Section scheduled to be repealed on July 1, 2018)
10 Sec. 5A-2. Assessment.
11 (a) Subject to Sections 5A-3 and 5A-10, for State fiscal
12 years 2009 through 2018, an annual assessment on inpatient
13 services is imposed on each hospital provider in an amount
14 equal to $218.38 multiplied by the difference of the hospital's
15 occupied bed days less the hospital's Medicare bed days,
16 provided, however, that the amount of $218.38 shall be
17 increased by a uniform percentage to generate an amount equal
18 to 75% of the State share of the payments authorized under
19 Section 12-5, with such increase only taking effect upon the
20 date that a State share for such payments is required under
21 federal law. For the period of April through June 2015, the
22 amount of $218.38 used to calculate the assessment under this
23 paragraph shall, by emergency rule under subsection (s) of
24 Section 5-45 of the Illinois Administrative Procedure Act, be
25 increased by a uniform percentage to generate $20,250,000 in

1 the aggregate for that period from all hospitals subject to the
2 annual assessment under this paragraph. In lieu of a reduction
3 in the reimbursement rates paid to hospitals under Section
4 5-5b.2 of this Code, for State fiscal year 2016, the amount of
5 $218.38 used to calculate the assessment under this paragraph
6 shall, by emergency rule under subsection (s) of Section 5-45
7 of the Illinois Administrative Procedure Act, be increased by a
8 uniform percentage to generate $20,250,000 annually in the
9 aggregate from all hospitals subject to the annual assessment
10 under this paragraph.

11 For State fiscal years 2009 through 2014 and after, a
12 hospital's occupied bed days and Medicare bed days shall be
13 determined using the most recent data available from each
14 hospital's 2005 Medicare cost report as contained in the
15 Healthcare Cost Report Information System file, for the quarter
16 ending on December 31, 2006, without regard to any subsequent
17 adjustments or changes to such data. If a hospital's 2005
18 Medicare cost report is not contained in the Healthcare Cost
19 Report Information System, then the Illinois Department may
20 obtain the hospital provider's occupied bed days and Medicare
21 bed days from any source available, including, but not limited
22 to, records maintained by the hospital provider, which may be
23 inspected at all times during business hours of the day by the
24 Illinois Department or its duly authorized agents and
25 employees.

26 (b) (Blank).

(b-5) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 12-5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days. For the period of April through June 2015, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the Illinois Administrative Procedure Act, be increased by a uniform percentage to generate $6,750,000 in the aggregate for that period from all hospitals subject to the annual assessment under this paragraph. In lieu of a reduction in the reimbursement rates paid to hospitals under Section 5-5b.2 of this Code, for State fiscal year 2016, the amount of .008766 used to calculate the assessment under this paragraph shall, by emergency rule under subsection (s) of Section 5-45 of the

1 Illinois Administrative Procedure Act, be increased by a
2 uniform percentage to generate $6,750,000 annually in the
3 aggregate from all hospitals subject to the annual assessment
4 under this paragraph.

5 For the portion of State fiscal year 2012, beginning June
6 10, 2012 through June 30, 2012, and State fiscal years 2013
7 through 2018, a hospital's outpatient gross revenue shall be
8 determined using the most recent data available from each
9 hospital's 2009 Medicare cost report as contained in the
10 Healthcare Cost Report Information System file, for the quarter
11 ending on June 30, 2011, without regard to any subsequent
12 adjustments or changes to such data. If a hospital's 2009
13 Medicare cost report is not contained in the Healthcare Cost
14 Report Information System, then the Department may obtain the
15 hospital provider's outpatient gross revenue from any source
16 available, including, but not limited to, records maintained by
17 the hospital provider, which may be inspected at all times
18 during business hours of the day by the Department or its duly
19 authorized agents and employees.

20 (c) (Blank).

21 (d) Notwithstanding any of the other provisions of this
22 Section, the Department is authorized to adopt rules to reduce
23 the rate of any annual assessment imposed under this Section,
24 as authorized by Section 5-46.2 of the Illinois Administrative
25 Procedure Act.

26 (e) Notwithstanding any other provision of this Section,

any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

(Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14; 99-2, eff. 3-26-15.)

(305 ILCS 5/5A-12.2)

(Section scheduled to be repealed on July 1, 2018)

Sec. 5A-12.2. Hospital access payments on or after July 1, 2008.

(a) To preserve and improve access to hospital services, for hospital services rendered on or after July 1, 2008, the Illinois Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as set forth in this Section. These payments shall be paid in 12 equal installments on or before the seventh State business day of each month, except that no payment shall be due within 100 days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act.

(a-5) The Illinois Department may, when practicable, accelerate the schedule upon which payments authorized under this Section are made.

1 (b) Across-the-board inpatient adjustment.
2 (1) In addition to rates paid for inpatient hospital
3 services, the Department shall pay to each Illinois general
4 acute care hospital an amount equal to 40% of the total
5 base inpatient payments paid to the hospital for services
6 provided in State fiscal year 2005.
7 (2) In addition to rates paid for inpatient hospital
8 services, the Department shall pay to each freestanding
9 Illinois specialty care hospital as defined in 89 Ill. Adm.
10 Code 149.50(c)(1), (2), or (4) an amount equal to 60% of
11 the total base inpatient payments paid to the hospital for
12 services provided in State fiscal year 2005.
13 (3) In addition to rates paid for inpatient hospital
14 services, the Department shall pay to each freestanding
15 Illinois rehabilitation or psychiatric hospital an amount
16 equal to $1,000 per Medicaid inpatient day multiplied by
17 the increase in the hospital's Medicaid inpatient
18 utilization ratio (determined using the positive
19 percentage change from the rate year 2005 Medicaid
20 inpatient utilization ratio to the rate year 2007 Medicaid
21 inpatient utilization ratio, as calculated by the
22 Department for the disproportionate share determination).
23 (4) In addition to rates paid for inpatient hospital
24 services, the Department shall pay to each Illinois
25 children's hospital an amount equal to 20% of the total
26 base inpatient payments paid to the hospital for services

1 provided in State fiscal year 2005 and an additional amount
2 equal to 20% of the base inpatient payments paid to the
3 hospital for psychiatric services provided in State fiscal
4 year 2005.

5 (5) In addition to rates paid for inpatient hospital
6 services, the Department shall pay to each Illinois
7 hospital eligible for a pediatric inpatient adjustment
8 payment under 89 Ill. Adm. Code 148.298, as in effect for
9 State fiscal year 2007, a supplemental pediatric inpatient
10 adjustment payment equal to:

11 (i) For freestanding children's hospitals as
12 defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5
13 multiplied by the hospital's pediatric inpatient
14 adjustment payment required under 89 Ill. Adm. Code
15 148.298, as in effect for State fiscal year 2008.

16 (ii) For hospitals other than freestanding
17 children's hospitals as defined in 89 Ill. Adm. Code
18 149.50(c)(3)(B), 1.0 multiplied by the hospital's
19 pediatric inpatient adjustment payment required under
20 89 Ill. Adm. Code 148.298, as in effect for State
21 fiscal year 2008.

22 (c) Outpatient adjustment.

23 (1) In addition to the rates paid for outpatient
24 hospital services, the Department shall pay each Illinois
25 hospital an amount equal to 2.2 multiplied by the
26 hospital's ambulatory procedure listing payments for

categories 1, 2, 3, and 4, as defined in 89 Ill. Adm. Code 148.140(b), for State fiscal year 2005.

(2) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois freestanding psychiatric hospital an amount equal to 3.25 multiplied by the hospital's ambulatory procedure listing payments for category 5b, as defined in 89 Ill. Adm. Code 148.140(b)(1)(E), for State fiscal year 2005.

(d) Medicaid high volume adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital that provided more than 20,500 Medicaid inpatient days of care in State fiscal year 2005 amounts as follows:

(1) For hospitals with a case mix index equal to or greater than the 85th percentile of hospital case mix indices, $350 for each Medicaid inpatient day of care provided during that period; and

(2) For hospitals with a case mix index less than the 85th percentile of hospital case mix indices, $100 for each Medicaid inpatient day of care provided during that period.

(e) Capital adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay an additional payment to each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 10% (as calculated by the Department for the rate year 2007 disproportionate share determination) amounts as follows:

1 (1) For each Illinois general acute care hospital that
2 has a Medicaid inpatient utilization rate of at least 10%
3 and less than 36.94% and whose capital cost is less than
4 the 60th percentile of the capital costs of all Illinois
5 hospitals, the amount of such payment shall equal the
6 hospital's Medicaid inpatient days multiplied by the
7 difference between the capital costs at the 60th percentile
8 of the capital costs of all Illinois hospitals and the
9 hospital's capital costs.
10 (2) For each Illinois general acute care hospital that
11 has a Medicaid inpatient utilization rate of at least
12 36.94% and whose capital cost is less than the 75th
13 percentile of the capital costs of all Illinois hospitals,
14 the amount of such payment shall equal the hospital's
15 Medicaid inpatient days multiplied by the difference
16 between the capital costs at the 75th percentile of the
17 capital costs of all Illinois hospitals and the hospital's
18 capital costs.
19 (f) Obstetrical care adjustment.
20 (1) In addition to rates paid for inpatient hospital
21 services, the Department shall pay $1,500 for each Medicaid
22 obstetrical day of care provided in State fiscal year 2005
23 by each Illinois rural hospital that had a Medicaid
24 obstetrical percentage (Medicaid obstetrical days divided
25 by Medicaid inpatient days) greater than 15% for State
26 fiscal year 2005.

1 (2) In addition to rates paid for inpatient hospital
2 services, the Department shall pay $1,350 for each Medicaid
3 obstetrical day of care provided in State fiscal year 2005
4 by each Illinois general acute care hospital that was
5 designated a level III perinatal center as of December 31,
6 2006, and that had a case mix index equal to or greater
7 than the 45th percentile of the case mix indices for all
8 level III perinatal centers.
9 (3) In addition to rates paid for inpatient hospital
10 services, the Department shall pay $900 for each Medicaid
11 obstetrical day of care provided in State fiscal year 2005
12 by each Illinois general acute care hospital that was
13 designated a level II or II+ perinatal center as of
14 December 31, 2006, and that had a case mix index equal to
15 or greater than the 35th percentile of the case mix indices
16 for all level II and II+ perinatal centers.
17 (g) Trauma adjustment.
18 (1) In addition to rates paid for inpatient hospital
19 services, the Department shall pay each Illinois general
20 acute care hospital designated as a trauma center as of
21 July 1, 2007, a payment equal to 3.75 multiplied by the
22 hospital's State fiscal year 2005 Medicaid capital
23 payments.
24 (2) In addition to rates paid for inpatient hospital
25 services, the Department shall pay $400 for each Medicaid
26 acute inpatient day of care provided in State fiscal year

2005 by each Illinois general acute care hospital that was designated a level II trauma center, as defined in 89 Ill. Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1, 2007.

(3) In addition to rates paid for inpatient hospital services, the Department shall pay $235 for each Illinois Medicaid acute inpatient day of care provided in State fiscal year 2005 by each level I pediatric trauma center located outside of Illinois that had more than 8,000 Illinois Medicaid inpatient days in State fiscal year 2005.

(h) Supplemental tertiary care adjustment. In addition to rates paid for inpatient services, the Department shall pay to each Illinois hospital eligible for tertiary care adjustment payments under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2007, a supplemental tertiary care adjustment payment equal to the tertiary care adjustment payment required under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2007.

(i) Crossover adjustment. In addition to rates paid for inpatient services, the Department shall pay each Illinois general acute care hospital that had a ratio of crossover days to total inpatient days for medical assistance programs administered by the Department (utilizing information from 2005 paid claims) greater than 50%, and a case mix index greater than the 65th percentile of case mix indices for all Illinois hospitals, a rate of $1,125 for each Medicaid

inpatient day including crossover days.

(j) Magnet hospital adjustment. In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital and each Illinois freestanding children's hospital that, as of February 1, 2008, was recognized as a Magnet hospital by the American Nurses Credentialing Center and that had a case mix index greater than the 75th percentile of case mix indices for all Illinois hospitals amounts as follows:

(1) For hospitals located in a county whose eligibility growth factor is greater than the mean, $450 multiplied by the eligibility growth factor for the county in which the hospital is located for each Medicaid inpatient day of care provided by the hospital during State fiscal year 2005.

(2) For hospitals located in a county whose eligibility growth factor is less than or equal to the mean, $225 multiplied by the eligibility growth factor for the county in which the hospital is located for each Medicaid inpatient day of care provided by the hospital during State fiscal year 2005.

For purposes of this subsection, "eligibility growth factor" means the percentage by which the number of Medicaid recipients in the county increased from State fiscal year 1998 to State fiscal year 2005.

(k) For purposes of this Section, a hospital that is enrolled to provide Medicaid services during State fiscal year

2005 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this Section.

(l) For purposes of this Section, the terms "Medicaid days", "ambulatory procedure listing services", and "ambulatory procedure listing payments" do not include any days, charges, or services for which Medicare or a managed care organization reimbursed on a capitated basis was liable for payment, except where explicitly stated otherwise in this Section.

(m) For purposes of this Section, in determining the percentile ranking of an Illinois hospital's case mix index or capital costs, hospitals described in subsection (b) of Section 5A-3 shall be excluded from the ranking.

(n) Definitions. Unless the context requires otherwise or unless provided otherwise in this Section, the terms used in this Section for qualifying criteria and payment calculations shall have the same meanings as those terms have been given in the Illinois Department's administrative rules as in effect on March 1, 2008. Other terms shall be defined by the Illinois Department by rule.

As used in this Section, unless the context requires otherwise:

"Base inpatient payments" means, for a given hospital, the sum of base payments for inpatient services made on a per diem or per admission (DRG) basis, excluding those portions of per

admission payments that are classified as capital payments. Disproportionate share hospital adjustment payments, Medicaid Percentage Adjustments, Medicaid High Volume Adjustments, and outlier payments, as defined by rule by the Department as of January 1, 2008, are not base payments.

"Capital costs" means, for a given hospital, the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, divided by the total inpatient days from the same cost report to calculate a capital cost per day. The resulting capital cost per day is inflated to the midpoint of State fiscal year 2009 utilizing the national hospital market price proxies (DRI) hospital cost index. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, the Department may obtain the data necessary to compute the hospital's capital costs from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

"Case mix index" means, for a given hospital, the sum of the DRG relative weighting factors in effect on January 1, 2005, for all general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code

148.82, divided by the total number of general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82.

"Medicaid inpatient day" means, for a given hospital, the sum of days of inpatient hospital days provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring during State fiscal year 2005 that was adjudicated by the Department through March 23, 2007.

"Medicaid obstetrical day" means, for a given hospital, the sum of days of inpatient hospital days grouped by the Department to DRGs of 370 through 375 provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for admissions occurring during State fiscal year 2005 that was adjudicated by the Department through March 23, 2007.

"Outpatient ambulatory procedure listing payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services, as described in 89 Ill. Adm. Code 148.140(b), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding

payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services occurring in State fiscal year 2005 that were adjudicated by the Department through March 23, 2007.

(o) The Department may adjust payments made under this Section 5A-12.2 to comply with federal law or regulations regarding hospital-specific payment limitations on government-owned or government-operated hospitals.

(p) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules that change the hospital access improvement payments specified in this Section, but only to the extent necessary to conform to any federally approved amendment to the Title XIX State plan. Any such rules shall be adopted by the Department as authorized by Section 5-50 of the Illinois Administrative Procedure Act. Notwithstanding any other provision of law, any changes implemented as a result of this subsection (p) shall be given retroactive effect so that they shall be deemed to have taken effect as of the effective date of this Section.

(q) (Blank).

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

(s) On or after July 1, 2014, but no later than October 1, 2014, and no less than annually thereafter, the Department may increase capitation payments to capitated managed care organizations (MCOs) to equal the aggregate reduction of payments made in this Section and in Section 5A-12.4 by a uniform percentage consistent with actuarial soundness ~~on a regional basis~~ to preserve access to hospital services for recipients under the Illinois Medical Assistance Program. The aggregate amount of all increased capitation payments to all MCOs for a fiscal year shall be an ~~the~~ amount needed to avoid reduction in payments authorized under Section 5A-15. Payments to MCOs under this Section shall be consistent with actuarial certification and shall be published by the Department each year. Each MCO shall only expend the increased capitation payments it receives under this Section to support the availability of hospital services and to ensure access to hospital services, with such expenditures being made within 15 calendar days from when the MCO receives the increased capitation payment. The Department shall make available, on a monthly basis, a report of the capitation payments that are made to each MCO pursuant to this subsection, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. Payments made under this subsection shall be guaranteed by a surety bond obtained by the MCO in an amount established by the Department to approximate one month's

1 liability of payments authorized under this subsection. The
2 Department may advance the payments guaranteed by the surety
3 bond. Payments to MCOs that would be paid consistent with
4 actuarial certification and enrollment in the absence of the
5 increased capitation payments under this Section shall not be
6 reduced as a consequence of payments made under this
7 subsection.

8 As used in this subsection, "MCO" means an entity which
9 contracts with the Department to provide services where payment
10 for medical services is made on a capitated basis.

11 (t) On or after July 1, 2014, the Department shall may
12 increase capitation payments to capitated managed care
13 organizations (MCOs) to include the payments authorized equal
14 the aggregate reduction of payments made in Section 5A-12.5 to
15 preserve access to hospital services for recipients under the
16 Illinois Medical Assistance Program. Payments to MCOs under
17 this Section shall be consistent with actuarial certification
18 and shall be published by the Department each year. Each MCO
19 shall only expend the increased capitation payments it receives
20 under this Section to support the availability of hospital
21 services and to ensure access to hospital services, with such
22 expenditures being made within 15 calendar days from when the
23 MCO receives the increased capitation payment. The Department
24 may advance the payments to hospitals under this subsection, in
25 the event the MCO fails to make such payments. The Department
26 shall make available, on a monthly basis, a report of the

capitation payments that are made to each MCO pursuant to this subsection, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this subsection shall not be reduced as a consequence of payments made under this subsection.

As used in this subsection, "MCO" means an entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

(Source: P.A. 97-689, eff. 6-14-12; 98-651, eff. 6-16-14.)

(305 ILCS 5/5A-12.5)

Sec. 5A-12.5. Affordable Care Act adults; hospital access payments. The Department shall, subject to federal approval, mirror the Medical Assistance hospital reimbursement methodology, for recipients enrolled under a fee for service or capitated managed care program, including hospital access payments as defined in Section 5A-12.2 of this Article and hospital access improvement payments as defined in Section 5A-12.4 of this Article, as well as the amount of such payments pursuant to subsection (s) of Section 5A-12.2 of this Article, in compliance with the equivalent rate provisions of the Affordable Care Act. The Department shall make adjustments to the capitation payments made to MCOs for adults eligible for

1 medical assistance pursuant to the Affordable Care Act for the
2 hospital access payments authorized under this Section
3 attributable to the earliest possible date for which federal
4 financial participation is available.
5 As used in this Section, "Affordable Care Act" is the
6 collective term for the Patient Protection and Affordable Care
7 Act (Pub. L. 111-148) and the Health Care and Education
8 Reconciliation Act of 2010 (Pub. L. 111-152).
9 (Source: P.A. 98-651, eff. 6-16-14.)

10 (305 ILCS 5/5A-13)
11 Sec. 5A-13. Emergency rulemaking.
12 (a) The Department of Healthcare and Family Services
13 (formerly Department of Public Aid) may adopt rules necessary
14 to implement this amendatory Act of the 94th General Assembly
15 through the use of emergency rulemaking in accordance with
16 Section 5-45 of the Illinois Administrative Procedure Act. For
17 purposes of that Act, the General Assembly finds that the
18 adoption of rules to implement this amendatory Act of the 94th
19 General Assembly is deemed an emergency and necessary for the
20 public interest, safety, and welfare.
21 (b) The Department of Healthcare and Family Services may
22 adopt rules necessary to implement this amendatory Act of the
23 97th General Assembly through the use of emergency rulemaking
24 in accordance with Section 5-45 of the Illinois Administrative
25 Procedure Act. For purposes of that Act, the General Assembly

finds that the adoption of rules to implement this amendatory Act of the 97th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

(c) The Department of Healthcare and Family Services may adopt rules necessary to implement this amendatory Act of the 99th General Assembly through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of this Code, the General Assembly finds that the adoption of rules to implement this amendatory Act of the 99th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare. The Department shall, within 30 days after the effective date of this amendatory Act of the 99th General Assembly, take all actions necessary to implement this amendatory Act of the 99th General Assembly, including, but not limited to, the adoption of rules and the obtaining of any necessary approval of the federal government.

(Source: P.A. 97-688, eff. 6-14-12.)

(305 ILCS 5/5G-10)

Sec. 5G-10. Assessment.

(a) Subject to Section 5G-45, beginning July 1, 2014, an annual assessment on health care services is imposed on each supportive living facility in an amount equal to $2.30 multiplied by the supportive living facility's care days. This assessment shall not be billed or passed on to any resident of

1 a supportive living facility.

2 (b) Nothing in this Section shall be construed to authorize
3 any home rule unit or other unit of local government to license
4 for revenue or impose a tax or assessment upon supportive
5 living facilities or the occupation of operating a supportive
6 living facility, or a tax or assessment measured by the income
7 or earnings or care days of a supportive living facility.

8 (c) The assessment imposed by this Section shall not be due
9 and payable, however, until after the Department notifies the
10 supportive living facilities, in writing, that the payment
11 methodologies to supportive living facilities required under
12 Section 5-5.01a of this Code have been approved by the Centers
13 for Medicare and Medicaid Services of the U.S. Department of
14 Health and Human Services and the waivers under 42 CFR 433.68
15 for the assessment imposed by this Section, if necessary, have
16 been granted by the Centers for Medicare and Medicaid Services
17 of the U.S. Department of Health and Human Services.

18 (d) The Department must contest the interpretation of
19 federal regulations on permissible provider taxes made by the
20 Centers for Medicare and Medicaid Services as stated in
21 correspondence dated January 20, 2015. The Department shall
22 submit a report to the General Assembly no later than January
23 1, 2016 detailing all actions taken to meet the requirement of
24 this subsection (d).

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

(305 ILCS 5/11-5.2)

Sec. 11-5.2. Income, Residency, and Identity Verification System.

(a) The Department shall ensure that its proposed integrated eligibility system shall include the computerized functions of income, residency, and identity eligibility verification to verify eligibility, eliminate duplication of medical assistance, and deter fraud. Until the integrated eligibility system is operational, the Department must ~~may~~ enter into a contract with the vendor selected pursuant to Section 11-5.3 as necessary to obtain the electronic data matching described in this Section. This contract shall be exempt from the Illinois Procurement Code pursuant to subsection (h) of Section 1-10 of that Code.

(b) Prior to awarding medical assistance at application under Article V of this Code, the Department shall, to the extent such databases are available to the Department, conduct data matches using the name, date of birth, address, and Social Security Number of each applicant or recipient or responsible relative of an applicant or recipient against the following:

(1) Income tax information.

(2) Employer reports of income and unemployment insurance payment information maintained by the Department of Employment Security.

(3) Earned and unearned income, citizenship and death, and other relevant information maintained by the Social

1 Security Administration.
2 (4) Immigration status information maintained by the
3 United States Citizenship and Immigration Services.
4 (5) Wage reporting and similar information maintained
5 by states contiguous to this State.
6 (6) Employment information maintained by the
7 Department of Employment Security in its New Hire Directory
8 database.
9 (7) Employment information maintained by the United
10 States Department of Health and Human Services in its
11 National Directory of New Hires database.
12 (8) Veterans' benefits information maintained by the
13 United States Department of Health and Human Services, in
14 coordination with the Department of Health and Human
15 Services and the Department of Veterans' Affairs, in the
16 federal Public Assistance Reporting Information System
17 (PARIS) database.
18 (9) Residency information maintained by the Illinois
19 Secretary of State.
20 (10) A database which is substantially similar to or a
21 successor of a database described in this Section that
22 contains information relevant for verifying eligibility
23 for medical assistance.
24 (c) (Blank).
25 (d) If a discrepancy results between information provided
26 by an applicant, recipient, or responsible relative and

information contained in one or more of the databases or information tools listed under subsection (b) of this Section or subsection (c) of Section 11-5.3 and that discrepancy calls into question the accuracy of information relevant to a condition of eligibility provided by the applicant, recipient, or responsible relative, the Department or its contractor shall review the applicant's or recipient's case using the following procedures:

(1) If the information discovered under subsection (b) of this Section or subsection (c) of Section 11-5.3 does not result in the Department finding the applicant or recipient ineligible for assistance under Article V of this Code, the Department shall finalize the determination or redetermination of eligibility.

(2) If the information discovered results in the Department finding the applicant or recipient ineligible for assistance, the Department shall provide notice as set forth in Section 11-7 of this Article.

(3) If the information discovered is insufficient to determine that the applicant or recipient is eligible or ineligible, the Department shall provide written notice to the applicant or recipient which shall describe in sufficient detail the circumstances of the discrepancy, the information or documentation required, the manner in which the applicant or recipient may respond, and the consequences of failing to take action. The applicant or

recipient shall have 10 business days to respond.

(4) If the applicant or recipient does not respond to the notice, the Department shall deny assistance for failure to cooperate, in which case the Department shall provide notice as set forth in Section 11-7. Eligibility for assistance shall not be established until the discrepancy has been resolved.

(5) If an applicant or recipient responds to the notice, the Department shall determine the effect of the information or documentation provided on the applicant's or recipient's case and shall take appropriate action. Written notice of the Department's action shall be provided as set forth in Section 11-7 of this Article.

(6) Suspected cases of fraud shall be referred to the Department's Inspector General.

(e) If the Department deems there is no responsible bidder to perform the contract offered pursuant to this Section, the Department may re-advertise and solicit other bids for the contract.

(f) ~~(e)~~ The Department shall adopt any rules necessary to implement this Section.

(Source: P.A. 97-689, eff. 6-14-12; 98-756, eff. 7-16-14.)

(305 ILCS 5/11-5.4)

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

1 (a) An expedited long-term care eligibility determination
2 and enrollment system shall be established to reduce long-term
3 care determinations to 90 days or fewer by July 1, 2014 and
4 streamline the long-term care enrollment process.
5 Establishment of the system shall be a joint venture of the
6 Department of Human Services and Healthcare and Family Services
7 and the Department on Aging. The Governor shall name a lead
8 agency no later than 30 days after the effective date of this
9 amendatory Act of the 98th General Assembly to assume
10 responsibility for the full implementation of the
11 establishment and maintenance of the system. Project outcomes
12 shall include an enhanced eligibility determination tracking
13 system accessible to providers and a centralized application
14 review and eligibility determination with all applicants
15 reviewed within 90 days of receipt by the State of a complete
16 application. If the Department of Healthcare and Family
17 Services' Office of the Inspector General determines that there
18 is a likelihood that a non-allowable transfer of assets has
19 occurred, and the facility in which the applicant resides is
20 notified, an extension of up to 90 days shall be permissible.
21 On or before December 31, 2015, a streamlined application and
22 enrollment process shall be put in place based on the following
23 principles:
24 (1) Minimize the burden on applicants by collecting
25 only the data necessary to determine eligibility for
26 medical services, long-term care services, and spousal

1 impoverishment offset.
2 (2) Integrate online data sources to simplify the
3 application process by reducing the amount of information
4 needed to be entered and to expedite eligibility
5 verification.
6 (3) Provide online prompts to alert the applicant that
7 information is missing or not complete.
8 (b) The Department shall, on or before July 1, 2014, assess
9 the feasibility of incorporating all information needed to
10 determine eligibility for long-term care services, including
11 asset transfer and spousal impoverishment financials, into the
12 State's integrated eligibility system identifying all
13 resources needed and reasonable timeframes for achieving the
14 specified integration.
15 (c) The lead agency shall file interim reports with the
16 Chairs and Minority Spokespersons of the House and Senate Human
17 Services Committees no later than September 1, 2013 and on
18 February 1, 2014. The Department of Healthcare and Family
19 Services shall include in the annual Medicaid report for State
20 Fiscal Year 2014 and every fiscal year thereafter information
21 concerning implementation of the provisions of this Section.
22 (d) No later than August 1, 2014, the Auditor General shall
23 report to the General Assembly concerning the extent to which
24 the timeframes specified in this Section have been met and the
25 extent to which State staffing levels are adequate to meet the
26 requirements of this Section.

1 (e) The Department of Healthcare and Family Services, the
2 Department of Human Services, and the Department on Aging shall
3 take the following steps to achieve federally established
4 timeframes for eligibility determinations for Medicaid and
5 long-term care benefits and shall work toward the federal goal
6 of real time determinations:
7 (1) The Departments shall review, in collaboration
8 with representatives of affected providers, all forms and
9 procedures currently in use, federal guidelines either
10 suggested or mandated, and staff deployment by September
11 30, 2014 to identify additional measures that can improve
12 long-term care eligibility processing and make adjustments
13 where possible.
14 (2) No later than June 30, 2014, the Department of
15 Healthcare and Family Services shall issue vouchers for
16 advance payments not to exceed $50,000,000 to nursing
17 facilities with significant outstanding Medicaid liability
18 associated with services provided to residents with
19 Medicaid applications pending and residents facing the
20 greatest delays. Each facility with an advance payment
21 shall state in writing whether its own recoupment schedule
22 will be in 3 or 6 equal monthly installments, as long as
23 all advances are recouped by June 30, 2016. Effective
24 February 28, 2015, the posting of recoupment installments
25 of the advance payments shall be suspended until January 1,
26 2016. Beginning January 1, 2016, recoupments shall resume

according to the schedule previously selected by the facility until recoupment is complete ~~2015~~.

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

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

1 resource limit applies. Such simplified verification
2 policies shall apply to community cases as well as
3 long-term care cases.

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

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

22 (7) Effective 30 days after the completion of 3
23 regionally based trainings, nursing facilities shall
24 submit all applications for medical assistance online via
25 the Application for Benefits Eligibility (ABE) website.
26 This requirement shall extend to scanning and uploading

with the online application any required additional forms such as the Long Term Care Facility Notification and the Additional Financial Information for Long Term Care Applicants as well as scanned copies of any supporting documentation. Long-term care facility admission documents must be submitted as required in Section 5-5 of this Code. No local Department of Human Services office shall refuse to accept an electronically filed application.

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

1 whether to grant an extension, the Department of Human
2 Services or the Department of Healthcare and Family
3 Services' Office of the Inspector General shall take into
4 account what is in the best interest of the applicant. The
5 time limits for processing an application shall be tolled
6 during the period of any extension granted under this
7 subsection.

8 (9) The Department of Human Services and the Department
9 of Healthcare and Family Services must jointly compile data
10 on pending applications and post a monthly report on each
11 Department's website for the purposes of monitoring
12 long-term care eligibility processing. The report must
13 specify the number of applications pending long-term care
14 eligibility determination and admission in the following
15 categories:

16 (A) Length of time application is pending - 0 to 90
17 days, 91 days to 180 days, 181 days to 12 months, over
18 12 months to 18 months, over 18 months to 24 months,
19 and over 24 months.

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

1 information.

2 (C) Status of pending applications.

3 (f) Long-term care services shall be covered to the same
4 extent other medical assistance is covered for an individual
5 entitled to temporary coverage under law or court order because
6 the State failed to process the individual's application timely
7 under State and federal law and the individual did not cause
8 the delay. The Department of Healthcare and Family Services
9 shall immediately add the person to the facility's roster for
10 payment and notify the managed care organization of the
11 resident's change in payment status, if the resident is in a
12 managed care organization. If the applicant is subsequently
13 found to be ineligible for long-term care services under the
14 medical assistance program, the Department shall recover all
15 payments made to long-term care providers for services provided
16 to the individual during the temporary coverage period.

17 (Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14.)

18 (305 ILCS 5/12-4.49 new)

19 Sec. 12-4.49. Waiver proposal; working group. The
20 Department of Healthcare and Family Services shall convene a
21 working group in consultation with the Office of the Governor
22 to discuss the development of a revised proposal for the
23 research and demonstration project waiver proposal submitted
24 to the U.S. Department of Health and Human Services on June 4,
25 2014 under Section 1115 of the Social Security Act. The working

1 group shall include the following members:
2 (1) Three members of the General Assembly chosen by the
3 Speaker of the House of Representatives.
4 (2) Three members of the General Assembly chosen by the
5 Minority Leader of the House of Representatives.
6 (3) Three members of the General Assembly chosen by the
7 President of the Senate.
8 (4) Three members of the General Assembly chosen by the
9 Minority Leader of the Senate.
10 The purpose of the working group shall be to provide input
11 and advice to the Department and the Office of the Governor
12 with regard to the development of the proposal to utilize a
13 research and demonstration waiver. The working group shall meet
14 initially at the call of the Governor and at least once each
15 quarter year thereafter until the waiver either is approved by
16 the U.S. Department of Health and Human Services or expires.
17 The Department shall provide administrative support for the
18 working group.
19 Members shall not be compensated for their participation in
20 the working group but may receive reimbursement for travel
21 expenses.

22 (305 ILCS 5/12-4.50 new)
23 Sec. 12-4.50. Program efficiencies. It is the intent of the
24 General Assembly to improve efficiencies and coordinate care in
25 order to maximize health outcomes and access to care. The

1 Governor's Office shall direct the Department of Healthcare and
2 Family Services, in conjunction with the Department of Human
3 Services, the Department on Aging, and the Department of Public
4 Health, to initiate a review of all case management, care
5 coordination programs, and public health programs for
6 potential duplication of services. Each agency shall provide
7 the Department of Healthcare and Family Services with a copy of
8 its internal review by October 1, 2015. The Department shall
9 provide the Governor and the General Assembly with a report of
10 its findings by January 1, 2016. If duplicative services are
11 identified, the Department of Healthcare and Family Services
12 shall work in conjunction with the agencies providing
13 duplicative services to develop a policy or policies to ensure
14 efficient expenditure of State resources, to be completed by
15 December 31, 2016.

16 (305 ILCS 5/12-13.1)
17 Sec. 12-13.1. Inspector General.
18 (a) The Governor shall appoint, and the Senate shall
19 confirm, an Inspector General who shall function within the
20 Illinois Department of Public Aid (now Healthcare and Family
21 Services) and report to the Governor. The term of the Inspector
22 General shall expire on the third Monday of January, 1997 and
23 every 4 years thereafter.
24 (b) In order to prevent, detect, and eliminate fraud,
25 waste, abuse, mismanagement, and misconduct, the Inspector

General shall oversee the Department of Healthcare and Family Services' and the Department on Aging's integrity functions, which include, but are not limited to, the following:

(1) Investigation of misconduct by employees, vendors, contractors and medical providers, except for allegations of violations of the State Officials and Employees Ethics Act which shall be referred to the Office of the Governor's Executive Inspector General for investigation.

(2) Prepayment and post-payment audits of medical providers related to ensuring that appropriate payments are made for services rendered and to the prevention and recovery of overpayments.

(3) Monitoring of quality assurance programs administered by the Department of Healthcare and Family Services and the Community Care Program administered by the Department on Aging.

(4) Quality control measurements of the programs administered by the Department of Healthcare and Family Services and the Community Care Program administered by the Department on Aging.

(5) Investigations of fraud or intentional program violations committed by clients of the Department of Healthcare and Family Services and the Community Care Program administered by the Department on Aging.

(6) Actions initiated against contractors, vendors, or medical providers for any of the following reasons:

1 (A) Violations of the medical assistance program
2 and the Community Care Program administered by the
3 Department on Aging.
4 (B) Sanctions against providers brought in
5 conjunction with the Department of Public Health or the
6 Department of Human Services (as successor to the
7 Department of Mental Health and Developmental
8 Disabilities).
9 (C) Recoveries of assessments against hospitals
10 and long-term care facilities.
11 (D) Sanctions mandated by the United States
12 Department of Health and Human Services against
13 medical providers.
14 (E) Violations of contracts related to any
15 programs administered by the Department of Healthcare
16 and Family Services and the Community Care Program
17 administered by the Department on Aging.
18 (7) Representation of the Department of Healthcare and
19 Family Services at hearings with the Illinois Department of
20 Financial and Professional Regulation in actions taken
21 against professional licenses held by persons who are in
22 violation of orders for child support payments.
23 (b-5) At the request of the Secretary of Human Services,
24 the Inspector General shall, in relation to any function
25 performed by the Department of Human Services as successor to
26 the Department of Public Aid, exercise one or more of the

1 powers provided under this Section as if those powers related
2 to the Department of Human Services; in such matters, the
3 Inspector General shall report his or her findings to the
4 Secretary of Human Services.
5 (c) Notwithstanding, and in addition to, any other
6 provision of law, the Inspector General shall have access to
7 all information, personnel and facilities of the Department of
8 Healthcare and Family Services and the Department of Human
9 Services (as successor to the Department of Public Aid), their
10 employees, vendors, contractors and medical providers and any
11 federal, State or local governmental agency that are necessary
12 to perform the duties of the Office as directly related to
13 public assistance programs administered by those departments.
14 No medical provider shall be compelled, however, to provide
15 individual medical records of patients who are not clients of
16 the programs administered by the Department of Healthcare and
17 Family Services. State and local governmental agencies are
18 authorized and directed to provide the requested information,
19 assistance or cooperation.
20 For purposes of enhanced program integrity functions and
21 oversight, and to the extent consistent with applicable
22 information and privacy, security, and disclosure laws, State
23 agencies and departments shall provide the Office of Inspector
24 General access to confidential and other information and data,
25 and the Inspector General is authorized to enter into
26 agreements with appropriate federal agencies and departments

1 to secure similar data. This includes, but is not limited to,
2 information pertaining to: licensure; certification; earnings;
3 immigration status; citizenship; wage reporting; unearned and
4 earned income; pension income; employment; supplemental
5 security income; social security numbers; National Provider
6 Identifier (NPI) numbers; the National Practitioner Data Bank
7 (NPDB); program and agency exclusions; taxpayer identification
8 numbers; tax delinquency; corporate information; and death
9 records.
10 The Inspector General shall enter into agreements with
11 State agencies and departments, and is authorized to enter into
12 agreements with federal agencies and departments, under which
13 such agencies and departments shall share data necessary for
14 medical assistance program integrity functions and oversight.
15 The Inspector General shall enter into agreements with State
16 agencies and departments, and is authorized to enter into
17 agreements with federal agencies and departments, under which
18 such agencies shall share data necessary for recipient and
19 vendor screening, review, and investigation, including but not
20 limited to vendor payment and recipient eligibility
21 verification. The Inspector General shall develop, in
22 cooperation with other State and federal agencies and
23 departments, and in compliance with applicable federal laws and
24 regulations, appropriate and effective methods to share such
25 data. The Inspector General shall enter into agreements with
26 State agencies and departments, and is authorized to enter into

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

6 The Inspector General shall have the authority to deny
7 payment, prevent overpayments, and recover overpayments.

8 The Inspector General shall have the authority to deny or
9 suspend payment to, and deny, terminate, or suspend the
10 eligibility of, any vendor who fails to grant the Inspector
11 General timely access to full and complete records, including
12 records of recipients under the medical assistance program for
13 the most recent 6 years, in accordance with Section 140.28 of
14 Title 89 of the Illinois Administrative Code, and other
15 information for the purpose of audits, investigations, or other
16 program integrity functions, after reasonable written request
17 by the Inspector General.

18 (d) The Inspector General shall serve as the Department of
19 Healthcare and Family Services' primary liaison with law
20 enforcement, investigatory and prosecutorial agencies,
21 including but not limited to the following:

22 (1) The Department of State Police.

23 (2) The Federal Bureau of Investigation and other
24 federal law enforcement agencies.

25 (3) The various Inspectors General of federal agencies
26 overseeing the programs administered by the Department of

1 Healthcare and Family Services.
2 (4) The various Inspectors General of any other State
3 agencies with responsibilities for portions of programs
4 primarily administered by the Department of Healthcare and
5 Family Services.
6 (5) The Offices of the several United States Attorneys
7 in Illinois.
8 (6) The several State's Attorneys.
9 (7) The offices of the Centers for Medicare and
10 Medicaid Services that administer the Medicare and
11 Medicaid integrity programs.
12 The Inspector General shall meet on a regular basis with
13 these entities to share information regarding possible
14 misconduct by any persons or entities involved with the public
15 aid programs administered by the Department of Healthcare and
16 Family Services.
17 (e) All investigations conducted by the Inspector General
18 shall be conducted in a manner that ensures the preservation of
19 evidence for use in criminal prosecutions. If the Inspector
20 General determines that a possible criminal act relating to
21 fraud in the provision or administration of the medical
22 assistance program has been committed, the Inspector General
23 shall immediately notify the Medicaid Fraud Control Unit. If
24 the Inspector General determines that a possible criminal act
25 has been committed within the jurisdiction of the Office, the
26 Inspector General may request the special expertise of the

1 Department of State Police. The Inspector General may present
2 for prosecution the findings of any criminal investigation to
3 the Office of the Attorney General, the Offices of the several
4 United States Attorneys in Illinois or the several State's
5 Attorneys.
6 (f) To carry out his or her duties as described in this
7 Section, the Inspector General and his or her designees shall
8 have the power to compel by subpoena the attendance and
9 testimony of witnesses and the production of books, electronic
10 records and papers as directly related to public assistance
11 programs administered by the Department of Healthcare and
12 Family Services or the Department of Human Services (as
13 successor to the Department of Public Aid). No medical provider
14 shall be compelled, however, to provide individual medical
15 records of patients who are not clients of the Medical
16 Assistance Program.
17 (g) The Inspector General shall report all convictions,
18 terminations, and suspensions taken against vendors,
19 contractors and medical providers to the Department of
20 Healthcare and Family Services and to any agency responsible
21 for licensing or regulating those persons or entities.
22 (h) The Inspector General shall make annual reports,
23 findings, and recommendations regarding the Office's
24 investigations into reports of fraud, waste, abuse,
25 mismanagement, or misconduct relating to any programs
26 administered by the Department of Healthcare and Family

Services or the Department of Human Services (as successor to the Department of Public Aid) to the General Assembly and the Governor. These reports shall include, but not be limited to, the following information:

(1) Aggregate provider billing and payment information, including the number of providers at various Medicaid earning levels.

(2) The number of audits of the medical assistance program and the dollar savings resulting from those audits.

(3) The number of prescriptions rejected annually under the Department of Healthcare and Family Services' Refill Too Soon program and the dollar savings resulting from that program.

(4) Provider sanctions, in the aggregate, including terminations and suspensions.

(5) A detailed summary of the investigations undertaken in the previous fiscal year. These summaries shall comply with all laws and rules regarding maintaining confidentiality in the public aid programs.

(i) Nothing in this Section shall limit investigations by the Department of Healthcare and Family Services or the Department of Human Services that may otherwise be required by law or that may be necessary in their capacity as the central administrative authorities responsible for administration of their agency's programs in this State.

(j) The Inspector General may issue shields or other

distinctive identification to his or her employees not exercising the powers of a peace officer if the Inspector General determines that a shield or distinctive identification is needed by an employee to carry out his or her responsibilities.

(k) The Office of Inspector General must realign its resources toward activities with the greatest potential to reduce or avoid unnecessary, wasteful, or fraudulent expenditures.

(Source: P.A. 97-689, eff. 6-14-12; 98-8, eff. 5-3-13.)

(305 ILCS 5/14-11)

Sec. 14-11. Hospital payment reform.

(a) The Department may, by rule, implement the All Patient Refined Diagnosis Related Groups (APR-DRG) payment system for inpatient services provided on or after July 1, 2013, in a manner consistent with the actions authorized in this Section.

(b) On or before October 1, 2012 and through June 30, 2013, the Department shall begin testing the APR-DRG system. During the testing period the Department shall process and price inpatient services using the APR-DRG system; however, actual payments for those inpatient services shall be made using the current reimbursement system. During the testing period, the Department, in collaboration with the statewide representative of hospitals, shall provide information and technical assistance to hospitals to encourage and facilitate their

1 transition to the APR-DRG system.

2 (c) The Department may, by rule, implement the Enhanced
3 Ambulatory Procedure Grouping (EAPG) system for outpatient
4 services provided on or after January 1, 2014, in a manner
5 consistent with the actions authorized in this Section. On or
6 before January 1, 2013 and through December 31, 2013, the
7 Department shall begin testing the EAPG system. During the
8 testing period the Department shall process and price
9 outpatient services using the EAPG system; however, actual
10 payments for those outpatient services shall be made using the
11 current reimbursement system. During the testing period, the
12 Department, in collaboration with the statewide representative
13 of hospitals, shall provide information and technical
14 assistance to hospitals to encourage and facilitate their
15 transition to the EAPG system.

16 (d) The Department in consultation with the current
17 hospital technical advisory group shall review the test claims
18 for inpatient and outpatient services at least monthly,
19 including the estimated impact on hospitals, and, in developing
20 the rules, policies, and procedures to implement the new
21 payment systems, shall consider at least the following issues:

22 (1) The use of national relative weights provided by
23 the vendor of the APR-DRG system, adjusted to reflect
24 characteristics of the Illinois Medical Assistance
25 population.

26 (2) An updated outlier payment methodology based on

1 current data and consistent with the APR-DRG system.
2 (3) The use of policy adjusters to enhance payments to
3 hospitals treating a high percentage of individuals
4 covered by the Medical Assistance program and uninsured
5 patients.
6 (4) Reimbursement for inpatient specialty services
7 such as psychiatric, rehabilitation, and long-term acute
8 care using updated per diem rates that account for service
9 acuity.
10 (5) The creation of one or more transition funding
11 pools to preserve access to care and to ensure financial
12 stability as hospitals transition to the new payment
13 system.
14 (6) Whether, beginning July 1, 2014, some of the static
15 adjustment payments financed by General Revenue funds
16 should be used as part of the base payment system,
17 including as policy adjusters to recognize the additional
18 costs of certain services, such as pediatric or neonatal,
19 or providers, such as trauma centers, Critical Access
20 Hospitals, or high Medicaid hospitals, or for services to
21 uninsured patients.
22 (e) The Department shall provide the association
23 representing the majority of hospitals in Illinois, as the
24 statewide representative of the hospital community, with a
25 monthly file of claims adjudicated under the test system for
26 the purpose of review and analysis as part of the collaboration

1 between the State and the hospital community. The file shall
2 consist of a de-identified extract compliant with the Health
3 Insurance Portability and Accountability Act (HIPAA).

4 (f) The current hospital technical advisory group shall
5 make recommendations for changes during the testing period and
6 recommendations for changes prior to the effective dates of the
7 new payment systems. The Department shall draft administrative
8 rules to implement the new payment systems and provide them to
9 the technical advisory group at least 90 days prior to the
10 proposed effective dates of the new payment systems.

11 (g) The payments to hospitals financed by the current
12 hospital assessment, authorized under Article V-A of this Code,
13 are scheduled to sunset on June 30, 2014. The continuation of
14 or revisions to the hospital assessment program shall take into
15 consideration the impact on hospitals and access to care as a
16 result of the changes to the hospital payment system.

17 (h) Beginning July 1, 2014, the Department may transition
18 current General Revenue funded supplemental payments into the
19 claims based system over a period of no less than 2 years from
20 the implementation date of the new payment systems and no more
21 than 4 years from the implementation date of the new payment
22 systems, provided however that the Department may adopt, by
23 rule, supplemental payments to help ensure access to care in a
24 geographic area or to help ensure access to specialty services.
25 For any supplemental payments that are adopted that are based
26 on historic data, the data shall be no older than 3 years and

1 the supplemental payment shall be effective for no longer than
2 2 years before requiring the data to be updated.
3 (i) Any payments authorized under 89 Illinois
4 Administrative Code 148 set to expire in State fiscal year 2012
5 and that were paid out to hospitals in State fiscal year 2012
6 or any payments authorized under 89 Illinois Administrative
7 Code 148.299(b)(1)(A) and initially paid out to hospitals in
8 State fiscal year 2015, shall remain in effect as long as the
9 assessment imposed by Section 5A-2 is in effect.
10 (j) Subsections (a) and (c) of this Section shall remain
11 operative unless the Auditor General has reported that: (i) the
12 Department has not undertaken the required actions listed in
13 the report required by subsection (a) of Section 2-20 of the
14 Illinois State Auditing Act; or (ii) the Department has failed
15 to comply with the reporting requirements of Section 2-20 of
16 the Illinois State Auditing Act.
17 (k) Subsections (a) and (c) of this Section shall not be
18 operative until final federal approval by the Centers for
19 Medicare and Medicaid Services of the U.S. Department of Health
20 and Human Services and implementation of all of the payments
21 and assessments in Article V-A in its form as of the effective
22 date of this amendatory Act of the 97th General Assembly or as
23 it may be amended.
24 (Source: P.A. 97-689, eff. 6-14-12.)

25 Section 99. Effective date. This Act takes effect upon

1 becoming law.".