**Rep. Greg Harris**

# Filed: 5/27/2015



AMENDMENT TO SENATE BILL 788

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

"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 January 1, 2015, and:

(1) is located: (A) in a municipality with a population of 50,000 or fewer inhabitants; (B) within 50 miles of the hospital that owns or controls the FEC; and (C) within 50 miles of the Resource Hospital affiliated with the FEC as

part of the EMS System;

(2) is wholly owned or controlled by an Associate or Resource Hospital, but is not a part of the hospital's physical plant;

(3) meets the standards for licensed FECs, adopted by rule of the Department, including, but not limited to:

(A) facility design, specification, operation, and maintenance standards;

(B) equipment standards; and

(C) the number and qualifications of emergency medical personnel and other staff, which must include at least one board certified emergency physician present at the FEC 24 hours per day.

(4) limits its participation in the EMS System strictly to receiving a limited number of BLS runs by emergency medical vehicles according to protocols developed by the Resource Hospital within the FEC's designated EMS System and approved by the Project Medical Director and the Department;

(5) provides comprehensive emergency treatment services, as defined in the rules adopted by the Department pursuant to the Hospital Licensing Act, 24 hours per day, on an outpatient basis;

(6) provides an ambulance and maintains on site ambulance services staffed with paramedics 24 hours per day;

(7) (blank);

(8) complies with all State and federal patient rights provisions, including, but not limited to, the Emergency Medical Treatment Act and the federal Emergency Medical Treatment and Active Labor Act;

(9) maintains a communications system that is fully integrated with its Resource Hospital within the FEC's designated EMS System;

(10) reports to the Department any patient transfers from the FEC to a hospital within 48 hours of the transfer plus any other data determined to be relevant by the Department;

(11) submits to the Department, on a quarterly basis, the FEC's morbidity and mortality rates for patients treated at the FEC and other data determined to be relevant by the Department;

(12) does not describe itself or hold itself out to the general public as a full service hospital or hospital emergency department in its advertising or marketing activities;

(13) complies with any other rules adopted by the Department under this Act that relate to FECs;

(14) passes the Department's site inspection for compliance with the FEC requirements of this Act;

(15) submits a copy of the permit issued by the Health Facilities and Services Review Board indicating that the

facility has complied with the Illinois Health Facilities Planning Act with respect to the health services to be provided at the facility;

(16) submits an application for designation as an FEC in a manner and form prescribed by the Department by rule; and

(17) pays the annual license fee as determined by the Department by rule.

(a-5) Notwithstanding any other provision of this Section, the Department may issue an annual FEC license to a facility that is located in a county that does not have a licensed general acute care hospital if the facility's application for a permit from the Illinois Health Facilities Planning Board has been deemed complete by the Department of Public Health by January 1, 2014 and if the facility complies with the requirements set forth in paragraphs (1) through (17) of subsection (a).

(a-10) Notwithstanding any other provision of this Section, the Department may issue an annual FEC license to a facility if the facility has, by January 1, 2014, filed a letter of intent to establish an FEC and if the facility complies with the requirements set forth in paragraphs (1) through (17) of subsection (a).

(a-15) Notwithstanding any other provision of this Section, the Department shall issue an annual FEC license to a facility located within a municipality with a population in

excess of 1,000,000 inhabitants if the facility (i) has, by January 1, 2016, filed a letter of intent to establish an FEC, (ii) has received a certificate of need from the Health Facilities and Services Review Board, and (iii) complies with all requirements set forth in paragraphs (3) through (17) of subsection (a) of this Section and all applicable administrative rules. Any FEC located in a municipality with a population in excess of 1,000,000 inhabitants shall not be required to be wholly owned or controlled by an Associate Hospital or Resource Hospital; however, all patients needing emergent or urgent evaluation or treatment beyond the FEC's ability shall be expeditiously transferred to the closest appropriate health care facility based on the patient's acuity and needs. The FEC shall have a transfer agreement in place with at least one acute care hospital in the FEC's service area within 30 minutes travel time of the FEC. The medical director of the FEC shall have full admitting privileges at a hospital with which the FEC has a transfer agreement and shall agree in writing to assume responsibility for all FEC patients requiring follow-up care in accordance with the transfer agreement. For 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, 11-5.4, 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 treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in

the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; (16.5) services delivered by facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013; and (17) any other medical care,

and any other type of remedial care recognized under the laws of this State, but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. The Illinois Department, by rule, shall prohibit any physician from providing medical assistance to anyone eligible therefor under this Code where such physician has been found guilty of performing an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

Notwithstanding any other provision of this Code, the Illinois Department may not require, as a condition of payment for any laboratory test authorized under this Article, that a

physician's handwritten signature appear on the laboratory test order form. The Illinois Department may, however, impose other appropriate requirements regarding laboratory test order documentation.

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

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

operated by the Department of Human Services as successor to the Department of Public Aid:

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

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

Notwithstanding any other provision of this Code and subject to federal approval, the Department may adopt rules to allow a dentist who is volunteering his or her service at no cost to render dental services through an enrolled not-for-profit health clinic without the dentist personally enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

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

The Department of Healthcare and Family Services must provide coverage and reimbursement for amino acid-based elemental formulas, regardless of delivery method, for the

diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

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

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

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

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

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

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

tool. For purposes of this Section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with an average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography.

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

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

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other hospital-based mammography facilities.

The Department shall establish a methodology to remind women who are age-appropriate for screening mammography, but who have not received a mammogram within the previous 18 months, of the importance and benefit of screening mammography.

The Department shall establish a performance goal for

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

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

Any medical or health care provider shall immediately recommend, to any pregnant woman who is being provided prenatal services and is suspected of drug abuse or is addicted as defined in the Alcoholism and Other Drug Abuse and Dependency 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.

The Illinois Department shall establish such regulations governing the dispensing of health services under this Article as it shall deem appropriate. The Department should seek the advice of formal professional advisory committees appointed by the Director of the Illinois Department for the purpose of

providing regular advice on policy and administrative matters, information dissemination and educational activities for medical and health care providers, and consistency in procedures to the Illinois Department.

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

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

(1) Physicians participating in a Partnership and providing certain services, which shall be determined by the Illinois Department, to persons in areas covered by the

Partnership may receive an additional surcharge for such services.

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

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

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

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

providers.

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

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

each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after the effective date of this amendatory Act of 1984, the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

The rules and regulations of the Illinois Department shall require that a written statement including the required opinion of a physician shall accompany any claim for reimbursement for 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 all financial, beneficial, ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services in this State under this Article.

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

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

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

Prior to enrollment and during the conditional enrollment period in the medical assistance program, all vendors shall be subject to enhanced oversight, screening, and review based on the risk of fraud, waste, and abuse that is posed by the category of risk of the vendor. The Illinois Department shall establish the procedures for oversight, screening, and review,

which may include, but need not be limited to: criminal and financial background checks; fingerprinting; license, certification, and authorization verifications; unscheduled or unannounced site visits; database checks; prepayment audit reviews; audits; payment caps; payment suspensions; and other screening as required by federal or State law.

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

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

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

the Illinois Department that the provider enrollment is complete.

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

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

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

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

In the case of long term care facilities, within 5 days of receipt by the facility of required prescreening information, data for new admissions shall be entered into the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System or successor system, and within 15 days of receipt by the facility of required

prescreening information, admission documents shall be submitted through MEDI or REV or shall be submitted directly to the Department of Human Services using required admission forms. Effective September 1, 2014, admission documents, including all prescreening information, must be submitted through MEDI or REV. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.

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

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

National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

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

Beginning in fiscal year 2013, the Illinois Department shall set forth a request for information to identify the benefits of a pre-payment, post-adjudication, and post-edit claims system with the goals of streamlining claims processing and provider reimbursement, reducing the number of pending or rejected claims, and helping to ensure a more transparent adjudication process through the utilization of: (i) provider

data verification and provider screening technology; and (ii) clinical code editing; and (iii) pre-pay, pre- or post-adjudicated predictive modeling with an integrated case management system with link analysis. Such a request for information shall not be considered as a request for proposal or as an obligation on the part of the Illinois Department to take any action or acquire any products or services.

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Subject to prior approval, such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department. <u>The Department may contract with one or more third-party vendors and suppliers to supply durable medical equipment in a more cost-effective manner.</u>

The Department shall execute, relative to the nursing home

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

not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

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

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

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

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

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

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

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The filing of one copy of the report with the Speaker, one copy with the Minority Leader and one copy with

the Clerk of the House of Representatives, one copy with the President, one copy with the Minority Leader and one copy with the Secretary of the Senate, one copy with the Legislative Research Unit, and such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act shall be deemed sufficient to comply with this Section.

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

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

Because kidney transplantation can be an appropriate, cost effective alternative to renal dialysis when medically necessary and notwithstanding the provisions of Section 1-11 of this Code, beginning October 1, 2014, the Department shall cover kidney transplantation for noncitizens with end-stage renal disease who are not eligible for comprehensive medical benefits, who meet the residency requirements of Section 5-3 of

this Code, and who would otherwise meet the financial requirements of the appropriate class of eligible persons under Section 5-2 of this Code. To qualify for coverage of kidney transplantation, such person must be receiving emergency renal dialysis services covered by the Department <u>for at least 2 years</u>. Providers under this Section shall be prior approved and certified by the Department to perform kidney transplantation and the services under this Section shall be limited to services associated with kidney transplantation.
(Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689, eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14; revised 10-2-14.)

(305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)

Sec. 5-5.2. Payment.

(a) All nursing facilities that are grouped pursuant to Section 5-5.1 of this Act shall receive the same rate of 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, 2012 shall be included.

(4) Case mix index shall be assigned to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study in effect on July 1, 2013, utilizing an index maximization approach.

(5) The pool of funds available for distribution by case mix and the base facility rate shall be determined using the formula contained in subsection (d-1).

(d-1) Calculation of base year Statewide RUG-IV nursing base per diem rate.

(1) Base rate spending pool shall be:

(A) The base year resident days which are calculated by multiplying the number of Medicaid residents in each nursing home as indicated in the MDS data defined in paragraph (4) by 365.

(B) Each facility's nursing component per diem in effect on July 1, 2012 shall be multiplied by subsection (A).

(C) Thirteen million is added to the product of subparagraph (A) and subparagraph (B) to adjust for the exclusion of nursing homes defined in paragraph (5).

(2) For each nursing home with Medicaid residents as indicated by the MDS data defined in paragraph (4), weighted days adjusted for case mix and regional wage adjustment shall be calculated. For each home this calculation is the product of:

(A) Base year resident days as calculated in subparagraph (A) of paragraph (1).

(B) The nursing home's regional wage adjustor based on the Health Service Areas (HSA) groupings and adjustors in effect on April 30, 2012.

(C) Facility weighted case mix which is the number of Medicaid residents as indicated by the MDS data defined in paragraph (4) multiplied by the associated case weight for the RUG-IV 48 grouper model using standard RUG-IV procedures for index maximization.

(D) The sum of the products calculated for each nursing home in subparagraphs (A) through (C) above shall be the base year case mix, rate adjusted weighted days.

(3) The Statewide RUG-IV nursing base per diem rate:

(A) on January 1, 2014 shall be the quotient of the paragraph (1) divided by the sum calculated under subparagraph (D) of paragraph (2); and

(B) on and after July 1, 2014, shall be the amount calculated under subparagraph (A) of this paragraph (3) plus $1.76.

(4) Minimum Data Set (MDS) comprehensive assessments for Medicaid residents on the last day of the quarter used to establish the base rate.

(5) Nursing facilities designated as of July 1, 2012 by 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

(B) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012 multiplied by 0.88.

(2) The transition RUG-IV per diem nursing rate for

nursing homes whose rate calculated in this subsection (e-2) is less 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

(B) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012 multiplied by 0.13.

(f) Notwithstanding any other provision of this Code, on and after July 1, 2012, reimbursement rates associated with the nursing or support components of the current nursing facility rate methodology shall not increase beyond the level effective May 1, 2011 until a new reimbursement system based on the RUGs IV 48 grouper model has been fully operationalized.

(g) Notwithstanding any other provision of this Code, on and after July 1, 2012, for facilities not designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease", rates effective May 1, 2011 shall be adjusted as follows:

(1) Individual nursing rates for residents classified in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter ending March 31, 2012 shall be reduced by 10%;

(2) Individual nursing rates for residents classified in all other RUG IV groups shall be reduced by 1.0%;

(3) Facility rates for the capital and support

components shall be reduced by 1.7%.

(h) Notwithstanding any other provision of this Code, on and after July 1, 2012, nursing facilities designated by the Department of Healthcare and Family Services as "Institutions for Mental Disease" and "Institutions for Mental Disease" that are facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall have the nursing, socio-developmental, capital, and support components of their reimbursement rate effective May 1, 2011 reduced in total by 2.7%.

(i) On and after July 1, 2014, the reimbursement rates for the support component of the nursing facility rate for facilities licensed under the Nursing Home Care Act as skilled or intermediate care facilities shall be the rate in effect on June 30, 2014 increased by 8.17%.

(j) The Department may contract with a third-party auditor to perform auditing to determine the accuracy of resident assessment information transmitted in the MDS that is relevant to the determination of reimbursement rates.

(Source: P.A. 97-689, eff. 6-14-12; 98-104, Article 6, Section 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.

(7) Services for the treatment of hemophilia.

(8) Physician services.

(9) Dental services.

(10) Optometric services.

(11) Podiatry services.

(12) Laboratory services or services provided by independent laboratories.

(13) Durable medical equipment and supplies.

(14) Renal dialysis services.

(15) Birth Center Services.

(16) Emergency services other than those offered by or in a hospital.

(b) No provider shall be exempt from the rate reductions authorized under this Section, except that rates or payments, or the portion thereof, paid for private duty nursing services or paid to a provider that is operated by a unit of government that provides the non-federal share of such services shall not be reduced as provided in this Section.

(b-1) The Department shall develop a State fiscal year 2016 blended rate for nursing services provided by facilities licensed under the Nursing Home Care Act that takes into account the State fiscal year 2016 appropriation from the Long-Term Care Provider Fund and the adjusted State fiscal year 2016 appropriation for nursing services from the General Revenue Fund. The State fiscal year 2016 blended rate shall 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 medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For

purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

(b) Payment for such coordinated care shall be based on arrangements where the State pays for performance related to health care outcomes, the use of evidence-based practices, the use of primary care delivered through comprehensive medical homes, the use of electronic medical records, and the appropriate exchange of health information electronically made either 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.

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of the effective date of this amendatory Act of the 96th General Assembly.

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program report, beginning April, 2012 until April, 2016, on the progress and implementation of the care coordination program initiatives established by the provisions of this amendatory Act of the 96th General Assembly. The Department shall include in its April 2011 report a full analysis of federal laws or regulations regarding upper payment limitations to providers 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 cost individuals or corridors of shared risk based on the overall cost of the total enrollment in the ACE. The ACE shall be responsible for claims processing, encounter data submission, utilization control, and quality assurance. The Department shall evaluate the ACE readiness to accept

capitation. The readiness review shall utilize written criteria that are shared with the ACEs and shall be completed 3 months prior to initiation of capitation payments. The Department shall establish by rule an appeals process for any ACE that has not met the Department's criteria for accepting capitation payments.

(8) In the fourth and subsequent years of operation, an ACE shall convert to a Managed Care Community Network (MCCN), as defined in this Article, or Health Maintenance Organization pursuant to the Illinois Insurance Code, accepting full-risk capitation payments.

The Department shall allow potential ACE entities 5 months from the date of the posting of the solicitation to submit proposals. After the solicitation is released, in addition to the MCO rate development data available on the Department's website, subject to federal and State confidentiality and privacy laws and regulations, the Department shall provide 2 years of de-identified summary service data on the targeted population, split between children and adults, showing the historical type and volume of services received and the cost of those services to those potential bidders that sign a data use agreement. The Department may add up to 2 non-state government employees with expertise in creating integrated delivery systems to its review team for the purchase of care solicitation described in this subsection. Any such individuals must sign a no-conflict disclosure and

confidentiality agreement and agree to act in accordance with all applicable State laws.

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

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

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

(h) Department contracts with MCOs and other entities reimbursed by risk based capitation shall have a minimum medical loss ratio of 85%, shall require the entity to establish an appeals and grievances process for consumers and providers, and shall require the entity to provide a quality assurance and utilization review program. Entities contracted with the Department to coordinate healthcare regardless of risk shall be measured utilizing the same quality metrics. The quality metrics may be population specific. Any contracted entity serving at least 5,000 seniors or people with disabilities or 15,000 individuals in other populations

covered by the Medical Assistance Program that has been receiving full-risk capitation for a year shall be accredited by a national accreditation organization authorized by the Department within 2 years after the date it is eligible to become accredited. The requirements of this subsection shall apply to contracts with MCOs entered into or renewed or extended after June 1, 2013.

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

(i) As used in this subsection:

"Care coordination entity" means a collaboration of providers and community agencies, governed by a lead entity, 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;

(5) enrolled in the DSCC Core Program; or

(6) placed in foster care with the Department of Children and Family Services.

The Department shall ensure that the parents of all eligible enrollees that are children with complex medical needs

shall receive notification of their eligibility and an explanation of how to elect the pediatric care coordination plan option. The Department shall ensure that any third-party enrollment broker is briefed on the pediatric care coordination plan option and that the broker shall ensure that all enrollment options are presented to the parents of children with complex medical needs.

The Department shall provide care coordination fees for care coordination entities for seniors and persons with disabilities and for pediatric care coordination entities for children with complex medical needs, except for a pediatric care coordination entity that had at least 1,500 enrollees as of March 1, 2015, for a period of at least 36 months of operation at a per member per month rate no less than the schedule of rates in effect as of January 1, 2015, or as agreed to by the CCE. The Department shall provide care coordination fees for pediatric care coordination entities for children with complex medical needs that had at least 1,500 enrollees as of March 1, 2015, until April 1, 2016, at a per member per month rate no less than the schedule of rates in effect as of January 1, 2015, or as agreed to by the CCE. After 24 months of operation, but before 36 months, the Department shall evaluate each CCE's performance in the areas of care coordination, clinical integration, quality measurement performance, including health care utilization, and health care expenditures. For purposes of this Section, a CCE's date of

operation shall be the month when care coordination payments were first paid. Nothing in this provision prohibits the following: (i) a CCE from partnering with another managed care entity, (ii) a CCE from moving to capitation sooner than the aforementioned timelines, and (iii) the Department from sanctioning or terminating a CCE for substantive contractual violations.

(Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13; 98-651, eff. 6-16-14.)

(305 ILCS 5/5-30.2 new)

Sec. 5-30.2. Managed care; automatic assignment. The Department shall, within a reasonable period of time after relevant data from managed care entities has been collected and analyzed, but no earlier than January 1, 2017, develop and implement within each enrollment region an algorithm that takes into account quality scores and other operational proficiency criteria developed, defined, and adopted by the Department, to automatically assign Medicaid enrollees served under the Family Health Plan and the Integrated Care Program and those Medicaid enrollees eligible for medical assistance pursuant to the Patient Protection and Affordable Care Act (Public Law 111-148) into managed care entities, including Accountable Care Entities, Managed Care Community Networks, and Managed Care Organizations. The quality metrics used shall be measurable for all entities. The algorithm shall not use the

quality and proficiency metrics to reassign enrollees out of any plan that they are enrolled with at the time and shall only be used if the client has not voluntarily selected a primary care physician and a managed care entity or care coordination entity. Clients shall have one opportunity within 90 calendar days after auto assignment by algorithm to select a different managed care entity. The algorithm developed and implemented shall favor assignment into managed care entities with the highest quality scores and levels of compliance with the operational proficiency criteria established.

(305 ILCS 5/5-30.3 new)

Sec. 5-30.3. Managed care; wards of the Department of Children and Family Services. The Department shall seek a waiver from the federal Centers for Medicare and Medicaid Services to allow mandatory enrollment of wards of the Department of Children and Family Services into Medicaid managed care and care coordination plans. The Department must submit a waiver request to the federal Centers for Medicare and Medicaid Services no later than October 1, 2015 and shall take all necessary actions to obtain approval, including appeal of any denial. Beginning January 1, 2016, the Department shall report progress on the waiver required under this Section and shall report quarterly until the waiver request is approved or denied. Upon federal approval, the Department shall develop a process to ensure that all wards of the Department of Children

and Family Services are enrolled in Medicaid managed care and care coordination plans.

(305 ILCS 5/5-30.4 new)

Sec. 5-30.4. Managed care capitated rates; specialized mental health rehabilitation facilities. Services delivered by facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall be a covered Medicaid service for eligible Medicaid enrollees under both fee-for-service, managed care, and care-coordination arrangements. The Department shall ensure that all residents of facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 who are eligible for Medicaid are enrolled in Medicaid managed care.

(305 ILCS 5/5-30.5 new)

Sec. 5-30.5. Managed care policy manual.

(a) The Department by January 1, 2016 must make available on its website a managed care policy manual for providers. The manual must be updated no less than annually, but may be updated no more frequently than monthly and no changes shall be effective until at least 30 days after the publication of the change in the manual. The manual and updates shall be developed and issued only after the Department has consulted with representatives of providers and managed care entities, including the Statewide associations representing such

stakeholders. Manuals posted pursuant to this Section shall be consistent with the Managed Care Reform and Patient Rights Act, the Health Maintenance Organization Act, and the Medicare-Medicaid Alignment Initiative (MMAI) Nursing Home Residents' Managed Care Rights Law, as applicable.

(b) The Department may post separate manuals based on the population served by the managed care coverage plan, such as seniors and people with disabilities. The Department must clearly distinguish any differences in information based on the managed care coverage plans.

(c) The manual must include no less than the following information: (i) the process for providers to appeal payment decisions made by the managed care plan, (ii) the process for enrollees to appeal decisions made by managed care entities, (iii) electronic links to information required for obtaining approval for services by each plan, (iv) the contact information for either a provider or an enrollee to file a complaint with the Department about a managed care plan, (v) the Department's requirements for each plan to provide services and timeliness of payment, (vi) all timeframes for each plan to approve or deny coverage, (vii) an electronic link to the information on identifying all the providers currently providing services for a managed care plan, (viii) the process and contact information for an enrollee to change managed care plans, (ix) contact information for an enrollee to change a primary care physician or correct personal information, and (x)

contact information for each plan for provider relations and customer service concerns.

(305 ILCS 5/5A-2) (from Ch. 23, par. 5A-2)

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

Sec. 5A-2. Assessment.

(a) Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2018, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided, however, that the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% 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 of April through June 2015, the amount of $218.38 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 $20,250,000 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 $218.38 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 $20,250,000 annually in the aggregate from all hospitals subject to the annual assessment under this paragraph.

For State fiscal years 2009 through 2014 and after, a hospital's occupied bed days and Medicare bed days shall be determined using the most recent data available from each hospital's 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, without regard to any subsequent adjustments or changes to such data. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Illinois Department may obtain the hospital provider's occupied bed days and Medicare bed days 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.

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

For the portion of State fiscal year 2012, beginning June

10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue 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 Department or its duly authorized agents and employees.

(c) (Blank).

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

(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.

(b) Across-the-board inpatient adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital an amount equal to 40% of the total base inpatient payments paid to the hospital for services

provided in State fiscal year 2005.

(2) In addition to rates paid for inpatient hospital services, the Department shall pay to each freestanding Illinois specialty care hospital as defined in 89 Ill. Adm. Code 149.50(c)(1), (2), or (4) an amount equal to 60% of the total base inpatient payments paid to the hospital for services provided in State fiscal year 2005.

(3) In addition to rates paid for inpatient hospital services, the Department shall pay to each freestanding Illinois rehabilitation or psychiatric hospital an amount equal to $1,000 per Medicaid inpatient day multiplied by the increase in the hospital's Medicaid inpatient utilization ratio (determined using the positive percentage change from the rate year 2005 Medicaid inpatient utilization ratio to the rate year 2007 Medicaid inpatient utilization ratio, as calculated by the Department for the disproportionate share determination).

(4) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois children's hospital an amount equal to 20% of the total base inpatient payments paid to the hospital for services provided in State fiscal year 2005 and an additional amount equal to 20% of the base inpatient payments paid to the hospital for psychiatric services provided in State fiscal year 2005.

(5) In addition to rates paid for inpatient hospital

services, the Department shall pay to each Illinois hospital eligible for a pediatric inpatient adjustment payment under 89 Ill. Adm. Code 148.298, as in effect for State fiscal year 2007, a supplemental pediatric inpatient adjustment payment equal to:

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

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

(c) Outpatient adjustment.

(1) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois hospital an amount equal to 2.2 multiplied by the 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) For each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 10% and less than 36.94% and whose capital cost is less than the 60th percentile of the capital costs of all Illinois hospitals, the amount of such payment shall equal the

hospital's Medicaid inpatient days multiplied by the difference between the capital costs at the 60th percentile of the capital costs of all Illinois hospitals and the hospital's capital costs.

(2) For each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 36.94% and whose capital cost is less than the 75th percentile of the capital costs of all Illinois hospitals, the amount of such payment shall equal the hospital's Medicaid inpatient days multiplied by the difference between the capital costs at the 75th percentile of the capital costs of all Illinois hospitals and the hospital's capital costs.

(f) Obstetrical care adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay $1,500 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois rural hospital that had a Medicaid obstetrical percentage (Medicaid obstetrical days divided by Medicaid inpatient days) greater than 15% for State fiscal year 2005.

(2) In addition to rates paid for inpatient hospital services, the Department shall pay $1,350 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois general acute care hospital that was designated a level III perinatal center as of December 31,

2006, and that had a case mix index equal to or greater than the 45th percentile of the case mix indices for all level III perinatal centers.

(3) In addition to rates paid for inpatient hospital services, the Department shall pay $900 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois general acute care hospital that was designated a level II or II+ perinatal center as of December 31, 2006, and that had a case mix index equal to or greater than the 35th percentile of the case mix indices for all level II and II+ perinatal centers.

(g) Trauma adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay each Illinois general acute care hospital designated as a trauma center as of July 1, 2007, a payment equal to 3.75 multiplied by the hospital's State fiscal year 2005 Medicaid capital payments.

(2) In addition to rates paid for inpatient hospital services, the Department shall pay $400 for each Medicaid 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 liability of payments authorized under this subsection. The Department may advance the payments guaranteed by the surety bond. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this Section 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.

(t) On or after July 1, 2014, the Department shall ~~may~~ increase capitation payments to capitated managed care organizations (MCOs) to include the payments authorized ~~equal the aggregate reduction of payments made~~ in Section 5A-12.5 to preserve access to hospital services for recipients under the Illinois Medical Assistance Program. 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 may advance the payments to hospitals under this subsection, in the event the MCO fails to make such payments. 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 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 medical assistance pursuant to the Affordable Care Act for the hospital access payments authorized under this Section attributable to the earliest possible date for which federal financial participation is available.

As used in this Section, "Affordable Care Act" is the

collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

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

(305 ILCS 5/5A-13)

Sec. 5A-13. Emergency rulemaking.

(a) The Department of Healthcare and Family Services (formerly Department of Public Aid) may adopt rules necessary to implement this amendatory Act of the 94th General Assembly through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the General Assembly finds that the adoption of rules to implement this amendatory Act of the 94th General Assembly is deemed an emergency and necessary for the public interest, safety, and welfare.

(b) The Department of Healthcare and Family Services may adopt rules necessary to implement this amendatory Act of the 97th General Assembly through the use of emergency rulemaking in accordance with Section 5-45 of the Illinois Administrative 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 a supportive living facility.

(b) Nothing in this Section shall be construed to authorize any home rule unit or other unit of local government to license for revenue or impose a tax or assessment upon supportive living facilities or the occupation of operating a supportive

living facility, or a tax or assessment measured by the income or earnings or care days of a supportive living facility.

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

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

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

(305 ILCS 5/11-5.4)

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

(a) An expedited long-term care eligibility determination and enrollment system shall be established to reduce long-term

care determinations to 90 days or fewer by July 1, 2014 and streamline the long-term care enrollment process. Establishment of the system shall be a joint venture of the Department of Human Services and Healthcare and Family Services and the Department on Aging. The Governor shall name a lead agency no later than 30 days after the effective date of this amendatory Act of the 98th General Assembly to assume responsibility for the full implementation of the establishment and maintenance of the system. Project outcomes shall include an enhanced eligibility determination tracking system accessible to providers and a centralized application review and eligibility determination with all applicants reviewed within 90 days of receipt by the State of a complete application. If the Department of Healthcare and Family Services' Office of the Inspector General determines that there is a likelihood that a non-allowable transfer of assets has occurred, and the facility in which the applicant resides is notified, an extension of up to 90 days shall be permissible. On or before December 31, 2015, a streamlined application and enrollment process shall be put in place based on the following principles:

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

(2) Integrate online data sources to simplify the

application process by reducing the amount of information needed to be entered and to expedite eligibility verification.

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

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

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

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

(e) The Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging shall

take the following steps to achieve federally established timeframes for eligibility determinations for Medicaid and long-term care benefits and shall work toward the federal goal of real time determinations:

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

(2) No later than June 30, 2014, the Department of Healthcare and Family Services shall issue vouchers for advance payments not to exceed $50,000,000 to nursing facilities with significant outstanding Medicaid liability associated with services provided to residents with Medicaid applications pending and residents facing the greatest delays. Each facility with an advance payment shall state in writing whether its own recoupment schedule will be in 3 or 6 equal monthly installments, as long as all advances are recouped by June 30, 2016. Effective February 28, 2015, the posting of recoupment installments of the advance payments shall be suspended until January 1, 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 resource limit applies. Such simplified verification policies shall apply to community cases as well as

long-term care cases.

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

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

(7) Effective 30 days after the completion of 3 regionally based trainings, nursing facilities shall submit all applications for medical assistance online via the Application for Benefits Eligibility (ABE) website. This requirement shall extend to scanning and uploading with the online application any required additional forms such as the Long Term Care Facility Notification and the

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

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

Services' Office of the Inspector General shall take into account what is in the best interest of the applicant. The time limits for processing an application shall be tolled during the period of any extension granted under this subsection.

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

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

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

(C) Status of pending applications.

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

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

(305 ILCS 5/12-4.49 new)

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

(1) Three members of the General Assembly chosen by the

Speaker of the House of Representatives.

(2) Three members of the General Assembly chosen by the Minority Leader of the House of Representatives.

(3) Three members of the General Assembly chosen by the President of the Senate.

(4) Three members of the General Assembly chosen by the Minority Leader of the Senate.

The purpose of the working group shall be to provide input and advice to the Department and the Office of the Governor with regard to the development of the proposal to utilize a research and demonstration waiver. The working group shall meet initially at the call of the Governor and at least once each quarter year thereafter until the waiver either is approved by the U.S. Department of Health and Human Services or expires. The Department shall provide administrative support for the working group.

Members shall not be compensated for their participation in the working group but may receive reimbursement for travel expenses.

(305 ILCS 5/12-4.50 new)

Sec. 12-4.50. Program efficiencies. It is the intent of the General Assembly to improve efficiencies and coordinate care in order to maximize health outcomes and access to care. The Governor's Office shall direct the Department of Healthcare and Family Services, in conjunction with the Department of Human

Services, the Department on Aging, and the Department of Public Health, to initiate a review of all case management, care coordination programs, and public health programs for potential duplication of services. Each agency shall provide the Department of Healthcare and Family Services with a copy of its internal review by October 1, 2015. The Department shall provide the Governor and the General Assembly with a report of its findings by January 1, 2016. If duplicative services are identified, the Department of Healthcare and Family Services shall work in conjunction with the agencies providing duplicative services to develop a policy or policies to ensure efficient expenditure of State resources, to be completed by December 31, 2016.

(305 ILCS 5/12-13.1)

Sec. 12-13.1. Inspector General.

(a) The Governor shall appoint, and the Senate shall confirm, an Inspector General who shall function within the Illinois Department of Public Aid (now Healthcare and Family Services) and report to the Governor. The term of the Inspector General shall expire on the third Monday of January, 1997 and every 4 years thereafter.

(b) In order to prevent, detect, and eliminate fraud, 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:

(A) Violations of the medical assistance program and the Community Care Program administered by the

Department on Aging.

(B) Sanctions against providers brought in conjunction with the Department of Public Health or the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities).

(C) Recoveries of assessments against hospitals and long-term care facilities.

(D) Sanctions mandated by the United States Department of Health and Human Services against medical providers.

(E) Violations of contracts related to any programs administered by the Department of Healthcare and Family Services and the Community Care Program administered by the Department on Aging.

(7) Representation of the Department of Healthcare and Family Services at hearings with the Illinois Department of Financial and Professional Regulation in actions taken against professional licenses held by persons who are in violation of orders for child support payments.

(b-5) At the request of the Secretary of Human Services, the Inspector General shall, in relation to any function performed by the Department of Human Services as successor to the Department of Public Aid, exercise one or more of the powers provided under this Section as if those powers related to the Department of Human Services; in such matters, the

Inspector General shall report his or her findings to the Secretary of Human Services.

(c) Notwithstanding, and in addition to, any other provision of law, the Inspector General shall have access to all information, personnel and facilities of the Department of Healthcare and Family Services and the Department of Human Services (as successor to the Department of Public Aid), their employees, vendors, contractors and medical providers and any federal, State or local governmental agency that are necessary to perform the duties of the Office as directly related to public assistance programs administered by those departments. No medical provider shall be compelled, however, to provide individual medical records of patients who are not clients of the programs administered by the Department of Healthcare and Family Services. State and local governmental agencies are authorized and directed to provide the requested information, assistance or cooperation.

For purposes of enhanced program integrity functions and oversight, and to the extent consistent with applicable information and privacy, security, and disclosure laws, State agencies and departments shall provide the Office of Inspector General access to confidential and other information and data, and the Inspector General is authorized to enter into agreements with appropriate federal agencies and departments to secure similar data. This includes, but is not limited to, information pertaining to: licensure; certification; earnings;

immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

The Inspector General shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Inspector General shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies shall share data necessary for recipient and vendor screening, review, and investigation, including but not limited to vendor payment and recipient eligibility verification. The Inspector General shall develop, in cooperation with other State and federal agencies and departments, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. The Inspector General shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including, but not limited to: the Secretary of State; the Department of

Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

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

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

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

(1) The Department of State Police.

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

(3) The various Inspectors General of federal agencies overseeing the programs administered by the Department of Healthcare and Family Services.

(4) The various Inspectors General of any other State

agencies with responsibilities for portions of programs primarily administered by the Department of Healthcare and Family Services.

(5) The Offices of the several United States Attorneys in Illinois.

(6) The several State's Attorneys.

(7) The offices of the Centers for Medicare and Medicaid Services that administer the Medicare and Medicaid integrity programs.

The Inspector General shall meet on a regular basis with these entities to share information regarding possible misconduct by any persons or entities involved with the public aid programs administered by the Department of Healthcare and Family Services.

(e) All investigations conducted by the Inspector General shall be conducted in a manner that ensures the preservation of evidence for use in criminal prosecutions. If the Inspector General determines that a possible criminal act relating to fraud in the provision or administration of the medical assistance program has been committed, the Inspector General shall immediately notify the Medicaid Fraud Control Unit. If the Inspector General determines that a possible criminal act has been committed within the jurisdiction of the Office, the Inspector General may request the special expertise of the Department of State Police. The Inspector General may present for prosecution the findings of any criminal investigation to

the Office of the Attorney General, the Offices of the several United States Attorneys in Illinois or the several State's Attorneys.

(f) To carry out his or her duties as described in this Section, the Inspector General and his or her designees shall have the power to compel by subpoena the attendance and testimony of witnesses and the production of books, electronic records and papers as directly related to public assistance programs administered by the Department of Healthcare and Family Services or the Department of Human Services (as successor to the Department of Public Aid). No medical provider shall be compelled, however, to provide individual medical records of patients who are not clients of the Medical Assistance Program.

(g) The Inspector General shall report all convictions, terminations, and suspensions taken against vendors, contractors and medical providers to the Department of Healthcare and Family Services and to any agency responsible for licensing or regulating those persons or entities.

(h) The Inspector General shall make annual reports, findings, and recommendations regarding the Office's investigations into reports of fraud, waste, abuse, mismanagement, or misconduct relating to any programs 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 transition to the APR-DRG system.

(c) The Department may, by rule, implement the Enhanced

Ambulatory Procedure Grouping (EAPG) system for outpatient services provided on or after January 1, 2014, in a manner consistent with the actions authorized in this Section. On or before January 1, 2013 and through December 31, 2013, the Department shall begin testing the EAPG system. During the testing period the Department shall process and price outpatient services using the EAPG system; however, actual payments for those outpatient 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 transition to the EAPG system.

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

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

(2) An updated outlier payment methodology based on current data and consistent with the APR-DRG system.

(3) The use of policy adjusters to enhance payments to

hospitals treating a high percentage of individuals covered by the Medical Assistance program and uninsured patients.

(4) Reimbursement for inpatient specialty services such as psychiatric, rehabilitation, and long-term acute care using updated per diem rates that account for service acuity.

(5) The creation of one or more transition funding pools to preserve access to care and to ensure financial stability as hospitals transition to the new payment system.

(6) Whether, beginning July 1, 2014, some of the static adjustment payments financed by General Revenue funds should be used as part of the base payment system, including as policy adjusters to recognize the additional costs of certain services, such as pediatric or neonatal, or providers, such as trauma centers, Critical Access Hospitals, or high Medicaid hospitals, or for services to uninsured patients.

(e) The Department shall provide the association representing the majority of hospitals in Illinois, as the statewide representative of the hospital community, with a monthly file of claims adjudicated under the test system for the purpose of review and analysis as part of the collaboration between the State and the hospital community. The file shall consist of a de-identified extract compliant with the Health

Insurance Portability and Accountability Act (HIPAA).

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

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

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

(i) Any payments authorized under 89 Illinois Administrative Code 148 set to expire in State fiscal year 2012 and that were paid out to hospitals in State fiscal year 2012 or any payments authorized under 89 Illinois Administrative Code 148.299(b)(1)(A) and initially paid out to hospitals in State fiscal year 2015, shall remain in effect as long as the assessment imposed by Section 5A-2 is in effect.

(j) Subsections (a) and (c) of this Section shall remain operative unless the Auditor General has reported that: (i) the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-20 of the Illinois State Auditing Act; or (ii) the Department has failed to comply with the reporting requirements of Section 2-20 of the Illinois State Auditing Act.

(k) Subsections (a) and (c) of this Section shall not be operative until final federal approval by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and implementation of all of the payments and assessments in Article V-A in its form as of the effective date of this amendatory Act of the 97th General Assembly or as it may be amended.

(Source: P.A. 97-689, eff. 6-14-12.)

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