Rep. Gregory Harris

Filed: 5/28/2018

AMENDMENT TO SENATE BILL 1851

AMENDMENT NO. _____. Amend Senate Bill 1851, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 1. Findings; intent. According to the Congressional Research Service reporting, approximately 35% to 60% of children placed in foster care have at least one chronic or acute physical health condition that requires treatment, including growth failure, asthma, obesity, vision impairment, hearing loss, neurological problems, and complex chronic illnesses; as many as 50% to 75% show behavioral or social competency issues that may warrant mental health services; many of these physical and mental health care issues persist and, relative to their peers in the general population, children who leave foster care for adoption and those who age out of care continue to have greater health needs.

Federal child welfare policy requires states to develop

strategies to address the health care needs of each child in foster care and mandates coordination of state child welfare and Medicaid agencies to ensure that the health care needs of children in foster care are properly identified and treated.

The Department of Children and Family Services is responsible for ensuring safety, family permanence, and well-being for the children placed in its custody and protecting these children from further trauma by ensuring timely access to appropriate placements and services, especially those children with complex emotional and behavioral needs who are at much greater risk for not achieving the fundamental child welfare goals of safety, permanence, and well-being.

The Department remains under federal court oversight pursuant to the B.H. Consent Decree, in part, for failure to provide constitutionally sufficient services and placements for children with psychological, behavioral, or emotional challenges; the 2015 court-appointed Expert Panel found too many children in the class experience multiple disruptions of placement, services, and relationships; these children and their families endure indeterminate waits, month upon month, for services the child and family need, without a concrete plan or timeframe; these disruptions and delays and the inaction of Department officials exacerbate children's already serious and chronic mental health problems; the Department's approach to treatment and its system of practice have been shaped by

crises, practitioner preferences, tradition, and system expediency.

The American Academy of Pediatrics cautions that the effects of managed care on children's access to services and actual health outcomes are not yet clear; it outlines design and implementation principles if managed care is to be implemented for children.

It is the intent of the General Assembly to ensure that children are provided a system of health care with full and inclusive access to physical and behavioral health services necessary for them to thrive.

The General Assembly finds it necessary to protect youth in care by requiring the Department to plan the use of managed care services transparently, collaboratively, and deliberately to ensure quality outcomes and accountable oversight.

Section 5. The Open Meetings Act is amended by changing Section 2 as follows:

(5 ILCS 120/2) (from Ch. 102, par. 42)

Sec. 2. Open meetings.

(a) Openness required. All meetings of public bodies shall be open to the public unless excepted in subsection (c) and closed in accordance with Section 2a.

(b) Construction of exceptions. The exceptions contained in subsection (c) are in derogation of the requirement that

public bodies meet in the open, and therefore, the exceptions are to be strictly construed, extending only to subjects clearly within their scope. The exceptions authorize but do not require the holding of a closed meeting to discuss a subject included within an enumerated exception.

(c) Exceptions. A public body may hold closed meetings to consider the following subjects:

(1) The appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity. However, a meeting to consider an increase in compensation to a specific employee of a public body that is subject to the Local Government Wage Increase Transparency Act may not be closed and shall be open to the public and posted and held in accordance with this Act.

(2) Collective negotiating matters between the public body and its employees or their representatives, or deliberations concerning salary schedules for one or more classes of employees.

(3) The selection of a person to fill a public office, as defined in this Act, including a vacancy in a public office, when the public body is given power to appoint under law or ordinance, or the discipline, performance or

removal of the occupant of a public office, when the public body is given power to remove the occupant under law or ordinance.

(4) Evidence or testimony presented in open hearing, or in closed hearing where specifically authorized by law, to a quasi-adjudicative body, as defined in this Act, provided that the body prepares and makes available for public inspection a written decision setting forth its determinative reasoning.

(5) The purchase or lease of real property for the use of the public body, including meetings held for the purpose of discussing whether a particular parcel should be acquired.

(6) The setting of a price for sale or lease of property owned by the public body.

(7) The sale or purchase of securities, investments, or investment contracts. This exception shall not apply to the investment of assets or income of funds deposited into the Illinois Prepaid Tuition Trust Fund.

(8) Security procedures, school building safety and security, and the use of personnel and equipment to respond to an actual, a threatened, or a reasonably potential danger to the safety of employees, students, staff, the public, or public property.

(9) Student disciplinary cases.

(10) The placement of individual students in special

education programs and other matters relating to individual students.

(11) Litigation, when an action against, affecting or on behalf of the particular public body has been filed and is pending before a court or administrative tribunal, or when the public body finds that an action is probable or imminent, in which case the basis for the finding shall be recorded and entered into the minutes of the closed meeting.

(12) The establishment of reserves or settlement of claims as provided in the Local Governmental and Governmental Employees Tort Immunity Act, if otherwise the disposition of a claim or potential claim might be prejudiced, or the review or discussion of claims, loss or risk management information, records, data, advice or communications from or with respect to any insurer of the public body or any intergovernmental risk management association or self insurance pool of which the public body is a member.

(13) Conciliation of complaints of discrimination in the sale or rental of housing, when closed meetings are authorized by the law or ordinance prescribing fair housing practices and creating a commission or administrative agency for their enforcement.

(14) Informant sources, the hiring or assignment of undercover personnel or equipment, or ongoing, prior or

future criminal investigations, when discussed by a public body with criminal investigatory responsibilities.

(15) Professional ethics or performance when considered by an advisory body appointed to advise a licensing or regulatory agency on matters germane to the advisory body's field of competence.

(16) Self evaluation, practices and procedures or professional ethics, when meeting with a representative of a statewide association of which the public body is a member.

(17) The recruitment, credentialing, discipline or formal peer review of physicians or other health care professionals, or for the discussion of matters protected under the federal Patient Safety and Quality Improvement Act of 2005, and the regulations promulgated thereunder, including 42 C.F.R. Part 3 (73 FR 70732), or the federal Health Insurance Portability and Accountability Act of 1996, and the regulations promulgated thereunder, including 45 C.F.R. Parts 160, 162, and 164, by a hospital, or other institution providing medical care, that is operated by the public body.

(18) Deliberations for decisions of the Prisoner Review Board.

(19) Review or discussion of applications received under the Experimental Organ Transplantation Procedures Act.

(20) The classification and discussion of matters classified as confidential or continued confidential by the State Government Suggestion Award Board.

(21) Discussion of minutes of meetings lawfully closed under this Act, whether for purposes of approval by the body of the minutes or semi-annual review of the minutes as mandated by Section 2.06.

(22) Deliberations for decisions of the State Emergency Medical Services Disciplinary Review Board.

(23) The operation by a municipality of a municipal utility or the operation of a municipal power agency or municipal natural gas agency when the discussion involves (i) contracts relating to the purchase, sale, or delivery of electricity or natural gas or (ii) the results or conclusions of load forecast studies.

(24) Meetings of a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(25) Meetings of an independent team of experts under Brian's Law.

(26) Meetings of a mortality review team appointed under the Department of Juvenile Justice Mortality Review Team Act.

(27) (Blank).

(28) Correspondence and records (i) that may not be

disclosed under Section 11-9 of the Illinois Public Aid Code or (ii) that pertain to appeals under Section 11-8 of the Illinois Public Aid Code.

(29) Meetings between internal or external auditors and governmental audit committees, finance committees, and their equivalents, when the discussion involves internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards of the United States of America.

(30) Those meetings or portions of meetings of a fatality review team or the Illinois Fatality Review Team Advisory Council during which a review of the death of an eligible adult in which abuse or neglect is suspected, alleged, or substantiated is conducted pursuant to Section 15 of the Adult Protective Services Act.

(31) Meetings and deliberations for decisions of the Concealed Carry Licensing Review Board under the Firearm Concealed Carry Act.

(32) Meetings between the Regional Transportation Authority Board and its Service Boards when the discussion involves review by the Regional Transportation Authority Board of employment contracts under Section 28d of the Metropolitan Transit Authority Act and Sections 3A.18 and 3B.26 of the Regional Transportation Authority Act.

(33) Those meetings or portions of meetings of the

advisory committee and peer review subcommittee created under Section 320 of the Illinois Controlled Substances Act during which specific controlled substance prescriber, dispenser, or patient information is discussed.

(34) Meetings of the Tax Increment Financing Reform Task Force under Section 2505-800 of the Department of Revenue Law of the Civil Administrative Code of Illinois.

(35) Meetings of the group established to discuss Medicaid capitation rates under Section 5-30.8 of the Illinois Public Aid Code.

(d) Definitions. For purposes of this Section:

"Employee" means a person employed by a public body whose relationship with the public body constitutes an employer-employee relationship under the usual common law rules, and who is not an independent contractor.

"Public office" means a position created by or under the Constitution or laws of this State, the occupant of which is charged with the exercise of some portion of the sovereign power of this State. The term "public office" shall include members of the public body, but it shall not include organizational positions filled by members thereof, whether established by law or by a public body itself, that exist to assist the body in the conduct of its business.

"Quasi-adjudicative body" means an administrative body charged by law or ordinance with the responsibility to conduct hearings, receive evidence or testimony and make

determinations based thereon, but does not include local electoral boards when such bodies are considering petition challenges.

(e) Final action. No final action may be taken at a closed meeting. Final action shall be preceded by a public recital of the nature of the matter being considered and other information that will inform the public of the business being conducted.

(Source: P.A. 99-78, eff. 7-20-15; 99-235, eff. 1-1-16; 99-480, eff. 9-9-15; 99-642, eff. 7-28-16; 99-646, eff. 7-28-16; 99-687, eff. 1-1-17; 100-201, eff. 8-18-17; 100-465, eff. 8-31-17.)

Section 10. The Freedom of Information Act is amended by changing Section 7.5 as follows:

(5 ILCS 140/7.5)

(Text of Section before amendment by P.A. 100-512 and 100-517)

Sec. 7.5. Statutory exemptions. To the extent provided for by the statutes referenced below, the following shall be exempt from inspection and copying:

(a) All information determined to be confidential under Section 4002 of the Technology Advancement and Development Act.

(b) Library circulation and order records identifying library users with specific materials under the Library

Records Confidentiality Act.

(c) Applications, related documents, and medical records received by the Experimental Organ Transplantation Procedures Board and any and all documents or other records prepared by the Experimental Organ Transplantation Procedures Board or its staff relating to applications it has received.

(d) Information and records held by the Department of Public Health and its authorized representatives relating to known or suspected cases of sexually transmissible disease or any information the disclosure of which is restricted under the Illinois Sexually Transmissible Disease Control Act.

(e) Information the disclosure of which is exempted under Section 30 of the Radon Industry Licensing Act.

(f) Firm performance evaluations under Section 55 of the Architectural, Engineering, and Land Surveying Qualifications Based Selection Act.

(g) Information the disclosure of which is restricted and exempted under Section 50 of the Illinois Prepaid Tuition Act.

(h) Information the disclosure of which is exempted under the State Officials and Employees Ethics Act, and records of any lawfully created State or local inspector general's office that would be exempt if created or obtained by an Executive Inspector General's office under

that Act.

(i) Information contained in a local emergency energy plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code.

(j) Information and data concerning the distribution of surcharge moneys collected and remitted by carriers under the Emergency Telephone System Act.

(k) Law enforcement officer identification information or driver identification information compiled by a law enforcement agency or the Department of Transportation under Section 11-212 of the Illinois Vehicle Code.

(l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(m) Information provided to the predatory lending database created pursuant to Article 3 of the Residential Real Property Disclosure Act, except to the extent authorized under that Article.

(n) Defense budgets and petitions for certification of compensation and expenses for court appointed trial counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act. This subsection (n) shall apply until the conclusion of the trial of the case, even if the prosecution chooses not to pursue the death penalty prior

to trial or sentencing.

(o) Information that is prohibited from being disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act.

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Regional Transportation Authority under Section 2.11 of the Regional Transportation Authority Act or the St. Clair County Transit District under the Bi-State Transit Safety Act.

(q) Information prohibited from being disclosed by the Personnel Records Review Act.

(r) Information prohibited from being disclosed by the Illinois School Student Records Act.

(s) Information the disclosure of which is restricted under Section 5-108 of the Public Utilities Act.

(t) All identified or deidentified health information in the form of health data or medical records contained in, stored in, submitted to, transferred by, or released from the Illinois Health Information Exchange, and identified or deidentified health information in the form of health data and medical records of the Illinois Health Information Exchange in the possession of the Illinois Health Information Exchange Authority due to its administration of the Illinois Health Information Exchange. The terms

"identified" and "deidentified" shall be given the same meaning as in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, or any subsequent amendments thereto, and any regulations promulgated thereunder.

(u) Records and information provided to an independent team of experts under Brian's Law.

(v) Names and information of people who have applied for or received Firearm Owner's Identification Cards under the Firearm Owners Identification Card Act or applied for or received a concealed carry license under the Firearm Concealed Carry Act, unless otherwise authorized by the Firearm Concealed Carry Act; and databases under the Firearm Concealed Carry Act, records of the Concealed Carry Licensing Review Board under the Firearm Concealed Carry Act, and law enforcement agency objections under the Firearm Concealed Carry Act.

(w) Personally identifiable information which is exempted from disclosure under subsection (g) of Section 19.1 of the Toll Highway Act.

(x) Information which is exempted from disclosure under Section 5-1014.3 of the Counties Code or Section 8-11-21 of the Illinois Municipal Code.

(y) Confidential information under the Adult Protective Services Act and its predecessor enabling statute, the Elder Abuse and Neglect Act, including

information about the identity and administrative finding against any caregiver of a verified and substantiated decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

(z) Records and information provided to a fatality review team or the Illinois Fatality Review Team Advisory Council under Section 15 of the Adult Protective Services Act.

(aa) Information which is exempted from disclosure under Section 2.37 of the Wildlife Code.

(bb) Information which is or was prohibited from disclosure by the Juvenile Court Act of 1987.

(cc) Recordings made under the Law Enforcement Officer-Worn Body Camera Act, except to the extent authorized under that Act.

(dd) Information that is prohibited from being disclosed under Section 45 of the Condominium and Common Interest Community Ombudsperson Act.

(ee) Information that is exempted from disclosure under Section 30.1 of the Pharmacy Practice Act.

(ff) Information that is exempted from disclosure under the Revised Uniform Unclaimed Property Act.

(gg) ~~(ff)~~ Information that is prohibited from being disclosed under Section 7-603.5 of the Illinois Vehicle Code.

(hh) ~~(ff)~~ Records that are exempt from disclosure under Section 1A-16.7 of the Election Code.

(ii) ~~(ff)~~ Information which is exempted from disclosure under Section 2505-800 of the Department of Revenue Law of the Civil Administrative Code of Illinois.

(ll) Information the disclosure of which is restricted and exempted under Section 5-30.8 of the Illinois Public Aid Code.

(Source: P.A. 99-78, eff. 7-20-15; 99-298, eff. 8-6-15; 99-352, eff. 1-1-16; 99-642, eff. 7-28-16; 99-776, eff. 8-12-16; 99-863, eff. 8-19-16; 100-20, eff. 7-1-17; 100-22, eff. 1-1-18; 100-201, eff. 8-18-17; 100-373, eff. 1-1-18; 100-464, eff. 8-28-17; 100-465, eff. 8-31-17; revised 11-2-17.)

(Text of Section after amendment by P.A. 100-517 but before amendment by P.A. 100-512)

Sec. 7.5. Statutory exemptions. To the extent provided for by the statutes referenced below, the following shall be exempt from inspection and copying:

(a) All information determined to be confidential under Section 4002 of the Technology Advancement and Development Act.

(b) Library circulation and order records identifying library users with specific materials under the Library Records Confidentiality Act.

(c) Applications, related documents, and medical

records received by the Experimental Organ Transplantation Procedures Board and any and all documents or other records prepared by the Experimental Organ Transplantation Procedures Board or its staff relating to applications it has received.

(d) Information and records held by the Department of Public Health and its authorized representatives relating to known or suspected cases of sexually transmissible disease or any information the disclosure of which is restricted under the Illinois Sexually Transmissible Disease Control Act.

(e) Information the disclosure of which is exempted under Section 30 of the Radon Industry Licensing Act.

(f) Firm performance evaluations under Section 55 of the Architectural, Engineering, and Land Surveying Qualifications Based Selection Act.

(g) Information the disclosure of which is restricted and exempted under Section 50 of the Illinois Prepaid Tuition Act.

(h) Information the disclosure of which is exempted under the State Officials and Employees Ethics Act, and records of any lawfully created State or local inspector general's office that would be exempt if created or obtained by an Executive Inspector General's office under that Act.

(i) Information contained in a local emergency energy

plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code.

(j) Information and data concerning the distribution of surcharge moneys collected and remitted by carriers under the Emergency Telephone System Act.

(k) Law enforcement officer identification information or driver identification information compiled by a law enforcement agency or the Department of Transportation under Section 11-212 of the Illinois Vehicle Code.

(l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(m) Information provided to the predatory lending database created pursuant to Article 3 of the Residential Real Property Disclosure Act, except to the extent authorized under that Article.

(n) Defense budgets and petitions for certification of compensation and expenses for court appointed trial counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act. This subsection (n) shall apply until the conclusion of the trial of the case, even if the prosecution chooses not to pursue the death penalty prior to trial or sentencing.

(o) Information that is prohibited from being

disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act.

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Regional Transportation Authority under Section 2.11 of the Regional Transportation Authority Act or the St. Clair County Transit District under the Bi-State Transit Safety Act.

(q) Information prohibited from being disclosed by the Personnel Records Review Act.

(r) Information prohibited from being disclosed by the Illinois School Student Records Act.

(s) Information the disclosure of which is restricted under Section 5-108 of the Public Utilities Act.

(t) All identified or deidentified health information in the form of health data or medical records contained in, stored in, submitted to, transferred by, or released from the Illinois Health Information Exchange, and identified or deidentified health information in the form of health data and medical records of the Illinois Health Information Exchange in the possession of the Illinois Health Information Exchange Authority due to its administration of the Illinois Health Information Exchange. The terms "identified" and "deidentified" shall be given the same meaning as in the Health Insurance Portability and

Accountability Act of 1996, Public Law 104-191, or any subsequent amendments thereto, and any regulations promulgated thereunder.

(u) Records and information provided to an independent team of experts under Brian's Law.

(v) Names and information of people who have applied for or received Firearm Owner's Identification Cards under the Firearm Owners Identification Card Act or applied for or received a concealed carry license under the Firearm Concealed Carry Act, unless otherwise authorized by the Firearm Concealed Carry Act; and databases under the Firearm Concealed Carry Act, records of the Concealed Carry Licensing Review Board under the Firearm Concealed Carry Act, and law enforcement agency objections under the Firearm Concealed Carry Act.

(w) Personally identifiable information which is exempted from disclosure under subsection (g) of Section 19.1 of the Toll Highway Act.

(x) Information which is exempted from disclosure under Section 5-1014.3 of the Counties Code or Section 8-11-21 of the Illinois Municipal Code.

(y) Confidential information under the Adult Protective Services Act and its predecessor enabling statute, the Elder Abuse and Neglect Act, including information about the identity and administrative finding against any caregiver of a verified and substantiated

decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

(z) Records and information provided to a fatality review team or the Illinois Fatality Review Team Advisory Council under Section 15 of the Adult Protective Services Act.

(aa) Information which is exempted from disclosure under Section 2.37 of the Wildlife Code.

(bb) Information which is or was prohibited from disclosure by the Juvenile Court Act of 1987.

(cc) Recordings made under the Law Enforcement Officer-Worn Body Camera Act, except to the extent authorized under that Act.

(dd) Information that is prohibited from being disclosed under Section 45 of the Condominium and Common Interest Community Ombudsperson Act.

(ee) Information that is exempted from disclosure under Section 30.1 of the Pharmacy Practice Act.

(ff) Information that is exempted from disclosure under the Revised Uniform Unclaimed Property Act.

(gg) ~~(ff)~~ Information that is prohibited from being disclosed under Section 7-603.5 of the Illinois Vehicle Code.

(hh) ~~(ff)~~ Records that are exempt from disclosure under Section 1A-16.7 of the Election Code.

(ii) ~~(ff)~~ Information which is exempted from disclosure under Section 2505-800 of the Department of Revenue Law of the Civil Administrative Code of Illinois.

(jj) ~~(fff)~~ Information and reports that are required to be submitted to the Department of Labor by registering day and temporary labor service agencies but are exempt from disclosure under subsection (a-1) of Section 45 of the Day and Temporary Labor Services Act.

(ll) Information the disclosure of which is restricted and exempted under Section 5-30.8 of the Illinois Public Aid Code.

(Source: P.A. 99-78, eff. 7-20-15; 99-298, eff. 8-6-15; 99-352, eff. 1-1-16; 99-642, eff. 7-28-16; 99-776, eff. 8-12-16; 99-863, eff. 8-19-16; 100-20, eff. 7-1-17; 100-22, eff. 1-1-18; 100-201, eff. 8-18-17; 100-373, eff. 1-1-18; 100-464, eff. 8-28-17; 100-465, eff. 8-31-17; 100-517, eff. 6-1-18; revised 11-2-17.)

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library users with specific materials under the Library Records Confidentiality Act.

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(h) Information the disclosure of which is exempted under the State Officials and Employees Ethics Act, and records of any lawfully created State or local inspector general's office that would be exempt if created or

obtained by an Executive Inspector General's office under that Act.

(i) Information contained in a local emergency energy plan submitted to a municipality in accordance with a local emergency energy plan ordinance that is adopted under Section 11-21.5-5 of the Illinois Municipal Code.

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(l) Records and information provided to a residential health care facility resident sexual assault and death review team or the Executive Council under the Abuse Prevention Review Team Act.

(m) Information provided to the predatory lending database created pursuant to Article 3 of the Residential Real Property Disclosure Act, except to the extent authorized under that Article.

(n) Defense budgets and petitions for certification of compensation and expenses for court appointed trial counsel as provided under Sections 10 and 15 of the Capital Crimes Litigation Act. This subsection (n) shall apply until the conclusion of the trial of the case, even if the

prosecution chooses not to pursue the death penalty prior to trial or sentencing.

(o) Information that is prohibited from being disclosed under Section 4 of the Illinois Health and Hazardous Substances Registry Act.

(p) Security portions of system safety program plans, investigation reports, surveys, schedules, lists, data, or information compiled, collected, or prepared by or for the Regional Transportation Authority under Section 2.11 of the Regional Transportation Authority Act or the St. Clair County Transit District under the Bi-State Transit Safety Act.

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of the Illinois Health Information Exchange. The terms "identified" and "deidentified" shall be given the same meaning as in the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, or any subsequent amendments thereto, and any regulations promulgated thereunder.

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(y) Confidential information under the Adult Protective Services Act and its predecessor enabling

statute, the Elder Abuse and Neglect Act, including information about the identity and administrative finding against any caregiver of a verified and substantiated decision of abuse, neglect, or financial exploitation of an eligible adult maintained in the Registry established under Section 7.5 of the Adult Protective Services Act.

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(bb) Information which is or was prohibited from disclosure by the Juvenile Court Act of 1987.

(cc) Recordings made under the Law Enforcement Officer-Worn Body Camera Act, except to the extent authorized under that Act.

(dd) Information that is prohibited from being disclosed under Section 45 of the Condominium and Common Interest Community Ombudsperson Act.

(ee) Information that is exempted from disclosure under Section 30.1 of the Pharmacy Practice Act.

(ff) Information that is exempted from disclosure under the Revised Uniform Unclaimed Property Act.

(gg) ~~(ff)~~ Information that is prohibited from being disclosed under Section 7-603.5 of the Illinois Vehicle

Code.

(hh) ~~(ff)~~ Records that are exempt from disclosure under Section 1A-16.7 of the Election Code.

(ii) ~~(ff)~~ Information which is exempted from disclosure under Section 2505-800 of the Department of Revenue Law of the Civil Administrative Code of Illinois.

(jj) ~~(ff)~~ Information and reports that are required to be submitted to the Department of Labor by registering day and temporary labor service agencies but are exempt from disclosure under subsection (a-1) of Section 45 of the Day and Temporary Labor Services Act.

(kk) ~~(ff)~~ Information prohibited from disclosure under the Seizure and Forfeiture Reporting Act.

(ll) Information the disclosure of which is restricted and exempted under Section 5-30.8 of the Illinois Public Aid Code.

(Source: P.A. 99-78, eff. 7-20-15; 99-298, eff. 8-6-15; 99-352, eff. 1-1-16; 99-642, eff. 7-28-16; 99-776, eff. 8-12-16; 99-863, eff. 8-19-16; 100-20, eff. 7-1-17; 100-22, eff. 1-1-18; 100-201, eff. 8-18-17; 100-373, eff. 1-1-18; 100-464, eff. 8-28-17; 100-465, eff. 8-31-17; 100-512, eff. 7-1-18; 100-517, eff. 6-1-18; revised 11-2-17.)

Section 15. The Children and Family Services Act is amended by adding Section 5.45 as follows:

(20 ILCS 505/5.45 new)

Sec. 5.45. Managed care plan services.

(a) As used in this Section:

"Caregiver" means an individual or entity directly providing the day-to-day care of a child ensuring the child's safety and well-being.

"Child" means a child placed in the care of the Department pursuant to the Juvenile Court Act of 1987.

"Department" means the Department of Children and Family Services, or any successor State agency.

"Director" means the Director of Children and Family Services.

"Managed care organization" has the meaning ascribed to that term in Section 5-30.1 of the Illinois Public Aid Code.

"Medicaid managed care plan" means a health care plan operated by a managed care organization under the Medical Assistance Program established in Article V of the Illinois Public Aid Code.

"Workgroup" means the Child Welfare Medicaid Managed Care Implementation Advisory Workgroup.

(b) Every child who is in the care of the Department pursuant to the Juvenile Court Act of 1987 shall receive the necessary services required by this Act and the Juvenile Court Act of 1987, including any child enrolled in a Medicaid managed care plan.

(c) The Department shall not relinquish its authority or

diminish its responsibility to determine and provide necessary services that are in the best interest of a child even if those services are directly or indirectly:

(1) provided by a managed care organization, another State agency, or other third parties;

(2) coordinated through a managed care organization, another State agency, or other third parties; or

(3) paid for by a managed care organization, another State agency, or other third parties.

(d) The Department shall:

(1) implement and enforce measures to ensure that a child's enrollment in Medicaid managed care supports continuity of treatment and does not hinder service delivery;

(2) establish a single point of contact for health care coverage inquiries and dispute resolution systemwide without transferring this responsibility to a third party such as a managed care coordinator;

(3) not require any child to participate in Medicaid managed care if the child would otherwise be exempt from enrolling in a Medicaid managed care plan under any rule or statute of this State; and

(4) make recommendations regarding managed care contract measures, quality assurance activities, and performance delivery evaluations in consultation with the Workgroup; and

(5) post on its website:

(A) a link to any rule adopted or procedures changed to address the provisions of this Section, if applicable;

(B) each managed care organization's contract, enrollee handbook, and directory;

(C) the notification process and timeframe requirements used to inform managed care plan enrollees, enrollees' caregivers, and enrollees' legal representation of any changes in health care coverage or change in a child's managed care provider;

(D) defined prior authorization requirements for prescriptions, goods, and services in emergency and non-emergency situations;

(E) the State's current Health Care Oversight and Coordination Plan developed in accordance with federal requirements; and

(F) the transition plan required under subsection (f), including:

(i) the public comments submitted to the Department, the Department of Healthcare and Family Services, and the Workgroup for consideration in development of the transition plan;

(ii) a list and summary of recommendations of the Workgroup that the Director or Director of

Healthcare and Family Services declined to adopt or implement; and

(iii) the Department's attestation that the transition plan will not impede the Department's ability to timely identify the service needs of youth in care and the timely and appropriate provision of services to address those identified needs.

(e) The Child Welfare Medicaid Managed Care Implementation Advisory Workgroup is established to advise the Department on the transition and implementation of managed care for children. The Director of Children and Family Services and the Director of Healthcare and Family Services shall serve as co-chairpersons of the Workgroup. The Directors shall jointly appoint members to the Workgroup who are stakeholders from the child welfare community, including:

(1) employees of the Department of Children and Family Services who have responsibility in the areas of (i) managed care services, (ii) performance monitoring and oversight, (iii) placement operations, and (iv) budget revenue maximization;

(2) employees of the Department of Healthcare and Family Services who have responsibility in the areas of (i) managed care contracting, (ii) performance monitoring and oversight, (iii) children's behavioral health, and (iv) budget revenue maximization;

(3) 2 representatives of youth in care;

(4) one representative of managed care organizations serving youth in care;

(5) 4 representatives of child welfare providers;

(6) one representative of parents of children in out-of-home care;

(7) one representative of universities or research institutions;

(8) one representative of pediatric physicians;

(9) one representative of the juvenile court;

(10) one representative of caregivers of youth in care;

(11) one practitioner with expertise in child and adolescent psychiatry;

(12) one representative of substance abuse and mental health providers with expertise in serving children involved in child welfare and their families;

(13) at least one member of the Medicaid Advisory Committee;

(14) one representative of a statewide organization representing hospitals;

(15) one representative of a statewide organization representing child welfare providers;

(16) one representative of a statewide organization representing substance abuse and mental health providers; and

(17) other child advocates as deemed appropriate by the

Directors.

To the greatest extent possible, the co-chairpersons shall appoint members who reflect the geographic diversity of the State and include members who represent rural service areas. Members shall serve 2-year terms or until the Workgroup dissolves. If a vacancy occurs in the Workgroup membership, the vacancy shall be filled in the same manner as the original appointment for the remainder of the unexpired term. The Workgroup shall hold meetings, as it deems appropriate, in the northern, central, and southern regions of the State to solicit public comments to develop its recommendations. To ensure the Department of Children and Family Services and the Department of Healthcare and Family Services are provided time to confer and determine their use of pertinent Workgroup recommendations in the transition plan required under subsection (f), the co-chairpersons shall convene at least 3 meetings. The Department of Children and Family Services and the Department of Healthcare and Family Services shall provide administrative support to the Workgroup. Workgroup members shall serve without compensation. The Workgroup shall dissolve 5 years after the Department of Children and Family Services' implementation of managed care.

(f) Prior to transitioning any child to managed care, the Department of Children and Family Services and the Department of Healthcare and Family Services, in consultation with the Workgroup, must develop and post publicly, a transition plan

for the provision of health care services to children enrolled in Medicaid managed care plans. Interim transition plans must be posted to the Department's website by July 15, 2018. The transition plan shall be posted at least 28 days before the Department's implementation of managed care. The transition plan shall address, but is not limited to, the following:

(1) an assessment of existing network adequacy, plans to address gaps in network, and ongoing network evaluation;

(2) a framework for preparing and training organizations, caregivers, frontline staff, and managed care organizations;

(3) the identification of administrative changes necessary for successful transition to managed care, and the timeframes to make changes;

(4) defined roles, responsibilities, and lines of authority for care coordination, placement providers, service providers, and each State agency involved in management and oversight of managed care services;

(5) data used to establish baseline performance and quality of care, which shall be utilized to assess quality outcomes and identify ongoing areas for improvement;

(6) a process for stakeholder input into managed care planning and implementation;

(7) a dispute resolution process, including the rights of enrollees and representatives of enrollees under the dispute process and timeframes for dispute resolution

determinations and remedies;

(8) the process for health care transition for youth exiting the Department's care through emancipation or achieving permanency; and

(9) protections to ensure the continued provision of health care services if a child's residence or legal guardian changes.

(g) Reports.

(1) On or before February 1, 2019, and on or before each February 1 thereafter, the Department shall submit a report to the House and Senate Human Services Committees, or to any successor committees, on measures of access to and the quality of health care services for children enrolled in Medicaid managed care plans, including, but not limited to, data showing whether:

(A) children enrolled in Medicaid managed care plans have continuity of care across placement types, geographic regions, and specialty service needs;

(B) each child is receiving the early periodic screening, diagnosis, and treatment services as required by federal law, including, but not limited to, regular preventative care and timely specialty care;

(C) children are assigned to health homes;

(D) each child has a health care oversight and coordination plan as required by federal law;

(E) there exist complaints and grievances

indicating gaps or barriers in service delivery; and

(F) the Workgroup and other stakeholders have and continue to be engaged in quality improvement initiatives.

The report shall be prepared in consultation with the Workgroup and other agencies, organizations, or individuals the Director deems appropriate in order to obtain comprehensive and objective information about the managed care plan operation.

(2) During each legislative session, the House and Senate Human Services Committees shall hold hearings to take public testimony about managed care implementation for children in the care of, adopted from, or placed in guardianship by the Department. The Department shall present testimony, including information provided in the report required under paragraph (1), the Department's compliance with the provisions of this Section, and any recommendations for statutory changes to improve health care for children in the Department's care.

(h) If any provision of this Section or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of this Section that can be given effect without the invalid provision or application.

Section 16. The Nursing Home Care Act is amended by

changing Section 2-217 as follows:

(210 ILCS 45/2-217)

Sec. 2-217. Order for transportation of resident by an ambulance service provider. If a facility orders medi-car, service car, or ground ambulance transportation of a resident of the facility by an ambulance service provider, the facility must maintain a written record that shows (i) the name of the person who placed the order for that transportation and (ii) the medical reason for that transportation. Additionally, the facility must provide the ambulance service provider with a Physician Certification Statement on a form prescribed by the Department of Healthcare and Family Services in accordance with subsection (g) of Section 5-4.2 of the Illinois Public Aid Code. The facility shall provide a copy of the Physician Certification Statement to the ambulance service provider prior to or at the time of transport. The Physician Certification Statement is not required prior to the transport if a delay in transport can be expected to negatively affect the patient outcome; however, the facility shall provide a copy of the Physician Certification Statement to the ambulance service provider at no charge within 10 days after the request. A facility shall, upon request, furnish assistance to the transportation provider in the completion of the form if the Physician Certification Statement is incomplete. The facility must maintain the record for a period of at least 3 years after

the date of the order for transportation by ambulance.
(Source: P.A. 94-1063, eff. 1-31-07.)

Section 17. The Specialized Mental Health Rehabilitation Act of 2013 is amended by adding Section 5-104 as follows:

(210 ILCS 49/5-104 new)

Sec. 5-104. Therapeutic visit rates. For a facility licensed under this Act by June 1, 2018 or provisionally licensed under this Act by June 1, 2018, a payment shall be made for therapeutic visits that have been indicated by an interdisciplinary team as therapeutically beneficial. Payment under this Section shall be at a rate of 75% of the facility's rate on the effective date of this amendatory Act of the 100th General Assembly and may not exceed 20 days in a fiscal year and shall not exceed 10 days consecutively.

Section 18. The Hospital Licensing Act is amended by changing Section 6.22 as follows:

(210 ILCS 85/6.22)

Sec. 6.22. Arrangement for transportation of patient by an ambulance service provider.

(a) In this Section:

"Ambulance service provider" means a Vehicle Service Provider as defined in the Emergency Medical Services (EMS)

Systems Act who provides non-emergency transportation services by ambulance.

"Patient" means a person who is transported by an ambulance service provider.

(b) If a hospital arranges for medi-car, service car, or ground ambulance transportation of a patient of the hospital ~~by ambulance~~, the hospital must provide the ambulance service provider, at or prior to transport, a Physician Certification Statement formatted and completed in compliance with federal regulations or an equivalent form developed by the hospital. Each hospital shall develop a policy requiring a physician or the physician's designee to complete the Physician Certification Statement. The Physician Certification Statement shall be maintained as part of the patient's medical record. A hospital shall, upon request, furnish assistance to the ambulance service provider in the completion of the form if the Physician Certification Statement is incomplete. The Physician Certification Statement or equivalent form is not required prior to transport if a delay in transport can be expected to negatively affect the patient outcome; however, a hospital shall provide a copy of the Physician Certification Statement to the ambulance service provider at no charge within 10 days after the request.

(c) If a hospital is unable to provide a Physician Certification Statement or equivalent form, then the hospital shall provide to the patient a written notice and a verbal

explanation of the written notice, which notice must meet all of the following requirements:

(1) The following caption must appear at the beginning of the notice in at least 14-point type: Notice to Patient Regarding Non-Emergency Ambulance Services.

(2) The notice must contain each of the following statements in at least 14-point type:

(A) The purpose of this notice is to help you make an informed choice about whether you want to be transported by ambulance because your medical condition does not meet medical necessity for transportation by an ambulance.

(B) Your insurance may not cover the charges for ambulance transportation.

(C) You may be responsible for the cost of ambulance transportation.

(D) The estimated cost of ambulance transportation is $(amount).

(3) The notice must be signed by the patient or by the patient's authorized representative. A copy shall be given to the patient and the hospital shall retain a copy.

(d) The notice set forth in subsection (c) of this Section shall not be required if a delay in transport can be expected to negatively affect the patient outcome.

(e) If a patient is physically or mentally unable to sign the notice described in subsection (c) of this Section and no

authorized representative of the patient is available to sign the notice on the patient's behalf, the hospital must be able to provide documentation of the patient's inability to sign the notice and the unavailability of an authorized representative. In any case described in this subsection (e), the hospital shall be considered to have met the requirements of subsection (c) of this Section.

(Source: P.A. 94-1063, eff. 1-31-07.)

Section 20. The Illinois Public Aid Code is amended by changing Sections 5-4.2, 5-5.4h, and 5A-16 and by adding Sections 5-5.07 and 5-30.8 as follows:

(305 ILCS 5/5-4.2) (from Ch. 23, par. 5-4.2)

Sec. 5-4.2. Ambulance services payments.

(a) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1993, the Illinois Department shall reimburse ambulance service providers at rates calculated in accordance with this Section. It is the intent of the General Assembly to provide adequate reimbursement for ambulance services so as to ensure adequate access to services for recipients of aid under this Article and to provide appropriate incentives to ambulance service providers to provide services in an efficient and cost-effective manner. Thus, it is the intent of the General Assembly that the Illinois Department implement a

reimbursement system for ambulance services that, to the extent practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, is consistent with the payment principles of Medicare. To ensure uniformity between the payment principles of Medicare and Medicaid, the Illinois Department shall follow, to the extent necessary and practicable and subject to the availability of funds appropriated by the General Assembly for this purpose, the statutes, laws, regulations, policies, procedures, principles, definitions, guidelines, and manuals used to determine the amounts paid to ambulance service providers under Title XVIII of the Social Security Act (Medicare).

(b) For ambulance services provided to a recipient of aid under this Article on or after January 1, 1996, the Illinois Department shall reimburse ambulance service providers based upon the actual distance traveled if a natural disaster, weather conditions, road repairs, or traffic congestion necessitates the use of a route other than the most direct route.

(c) For purposes of this Section, "ambulance services" includes medical transportation services provided by means of an ambulance, medi-car, service car, or taxi.

(c-1) For purposes of this Section, "ground ambulance service" means medical transportation services that are described as ground ambulance services by the Centers for Medicare and Medicaid Services and provided in a vehicle that

is licensed as an ambulance by the Illinois Department of Public Health pursuant to the Emergency Medical Services (EMS) Systems Act.

(c-2) For purposes of this Section, "ground ambulance service provider" means a vehicle service provider as described in the Emergency Medical Services (EMS) Systems Act that operates licensed ambulances for the purpose of providing emergency ambulance services, or non-emergency ambulance services, or both. For purposes of this Section, this includes both ambulance providers and ambulance suppliers as described by the Centers for Medicare and Medicaid Services.

(c-3) For purposes of this Section, "medi-car" means transportation services provided to a patient who is confined to a wheelchair and requires the use of a hydraulic or electric lift or ramp and wheelchair lockdown when the patient's condition does not require medical observation, medical supervision, medical equipment, the administration of medications, or the administration of oxygen.

(c-4) For purposes of this Section, "service car" means transportation services provided to a patient by a passenger vehicle where that patient does not require the specialized modes described in subsection (c-1) or (c-3).

(d) This Section does not prohibit separate billing by ambulance service providers for oxygen furnished while providing advanced life support services.

(e) Beginning with services rendered on or after July 1,

2008, all providers of non-emergency medi-car and service car transportation must certify that the driver and employee attendant, as applicable, have completed a safety program approved by the Department to protect both the patient and the driver, prior to transporting a patient. The provider must maintain this certification in its records. The provider shall produce such documentation upon demand by the Department or its representative. Failure to produce documentation of such training shall result in recovery of any payments made by the Department for services rendered by a non-certified driver or employee attendant. Medi-car and service car providers must maintain legible documentation in their records of the driver and, as applicable, employee attendant that actually transported the patient. Providers must recertify all drivers and employee attendants every 3 years.

Notwithstanding the requirements above, any public transportation provider of medi-car and service car transportation that receives federal funding under 49 U.S.C. 5307 and 5311 need not certify its drivers and employee attendants under this Section, since safety training is already federally mandated.

(f) With respect to any policy or program administered by the Department or its agent regarding approval of non-emergency medical transportation by ground ambulance service providers, including, but not limited to, the Non-Emergency Transportation Services Prior Approval Program (NETSPAP), the

Department shall establish by rule a process by which ground ambulance service providers of non-emergency medical transportation may appeal any decision by the Department or its agent for which no denial was received prior to the time of transport that either (i) denies a request for approval for payment of non-emergency transportation by means of ground ambulance service or (ii) grants a request for approval of non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than the ground ambulance service provider would have received as compensation for the level of service requested. The rule shall be filed by December 15, 2012 and shall provide that, for any decision rendered by the Department or its agent on or after the date the rule takes effect, the ground ambulance service provider shall have 60 days from the date the decision is received to file an appeal. The rule established by the Department shall be, insofar as is practical, consistent with the Illinois Administrative Procedure Act. The Director's decision on an appeal under this Section shall be a final administrative decision subject to review under the Administrative Review Law.

(f-5) Beginning 90 days after July 20, 2012 (the effective date of Public Act 97-842), (i) no denial of a request for approval for payment of non-emergency transportation by means of ground ambulance service, and (ii) no approval of

non-emergency transportation by means of ground ambulance service at a level of service that entitles the ground ambulance service provider to a lower level of compensation from the Department than would have been received at the level of service submitted by the ground ambulance service provider, may be issued by the Department or its agent unless the Department has submitted the criteria for determining the appropriateness of the transport for first notice publication in the Illinois Register pursuant to Section 5-40 of the Illinois Administrative Procedure Act.

(g) Whenever a patient covered by a medical assistance program under this Code or by another medical program administered by the Department, including a patient covered under the State's Medicaid managed care program, is being transported ~~discharged~~ from a facility and requires non-emergency transportation including ground ambulance, medi-car, or service car transportation, a Physician Certification Statement ~~, a physician discharge order~~ as described in this Section shall be required for each patient ~~whose discharge requires medically supervised ground ambulance services~~. Facilities shall develop procedures for a licensed medical professional ~~physician with medical staff privileges~~ to provide a written and signed Physician Certification Statement ~~physician discharge order~~. The Physician Certification Statement ~~physician discharge order~~ shall specify the level of transportation ~~ground ambulance~~ services

needed and complete a medical certification establishing the criteria for approval of non-emergency ambulance transportation, as published by the Department of Healthcare and Family Services, that is met by the patient. This ~~order and the medical~~ certification shall be completed prior to ordering the transportation ~~an ambulance~~ service and prior to patient discharge. The Physician Certification Statement is not required prior to transport if a delay in transport can be expected to negatively affect the patient outcome. ~~discharge.~~

The medical certification specifying the level and type of non-emergency transportation needed shall be in the form of the Physician Certification Statement on a standardized form prescribed by the Department of Healthcare and Family Services. Within 75 days after the effective date of this amendatory Act of the 100th General Assembly, the Department of Healthcare and Family Services shall develop a standardized form of the Physician Certification Statement specifying the level and type of transportation services needed in consultation with the Department of Public Health, Medicaid managed care organizations, a statewide association representing ambulance providers, a statewide association representing hospitals, 3 statewide associations representing nursing homes, and other stakeholders. The Physician Certification Statement shall include, but is not limited to, the criteria necessary to demonstrate medical necessity for the level of transport needed as required by (i) the Department of Healthcare and Family

Services and (ii) the federal Centers for Medicare and Medicaid Services as outlined in the Centers for Medicare and Medicaid Services' Medicare Benefit Policy Manual, Pub. 100-02, Chap. 10, Sec. 10.2.1, et seq. The use of the Physician Certification Statement shall satisfy the obligations of hospitals under Section 6.22 of the Hospital Licensing Act and nursing homes under Section 2-217 of the Nursing Home Care Act. Implementation and acceptance of the Physician Certification Statement shall take place no later than 90 days after the issuance of the Physician Certification Statement by the Department of Healthcare and Family Services.

Pursuant to subsection (E) of Section 12-4.25 of this Code, the Department is entitled to recover overpayments paid to a provider or vendor, including, but not limited to, from the discharging physician, the discharging facility, and the ground ambulance service provider, in instances where a non-emergency ground ambulance service is rendered as the result of improper or false certification.

Beginning October 1, 2018, the Department of Healthcare and Family Services shall collect data from Medicaid managed care organizations and transportation brokers, including the Department's NETSPAP broker, regarding denials and appeals related to the missing or incomplete Physician Certification Statement forms and overall compliance with this subsection. The Department of Healthcare and Family Services shall publish quarterly results on its website within 15 days following the

end of each quarter.

(h) 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.

(Source: P.A. 97-584, eff. 8-26-11; 97-689, eff. 6-14-12; 97-842, eff. 7-20-12; 98-463, eff. 8-16-13.)

(305 ILCS 5/5-5.4h)

Sec. 5-5.4h. Medicaid reimbursement for medically complex for the developmentally disabled facilities licensed under the MC/DD Act ~~long-term care facilities for persons under 22 years of age~~.

(a) Facilities licensed as medically complex for the developmentally disabled facilities ~~long-term care facilities for persons under 22 years of age~~ that serve severely and chronically ill ~~pediatric~~ patients shall have a specific reimbursement system designed to recognize the characteristics and needs of the patients they serve.

(b) For dates of services starting July 1, 2013 and until a new reimbursement system is designed, medically complex for the developmentally disabled facilities ~~long-term care facilities for persons under 22 years of age~~ that meet the following criteria:

(1) serve exceptional care patients; and

(2) have 30% or more of their patients receiving ventilator care;

shall receive Medicaid reimbursement on a 30-day expedited schedule.

(c) Subject to federal approval of changes to the Title XIX State Plan, for dates of services starting July 1, 2014 through March 31, 2019, medically complex for the developmentally disabled facilities ~~and until a new reimbursement system is designed, long-term care facilities for persons under 22 years of age~~ which meet the criteria in subsection (b) of this Section shall receive a per diem rate for clinically complex residents of $304. Clinically complex residents on a ventilator shall receive a per diem rate of $669. Subject to federal approval of changes to the Title XIX State Plan, for dates of services starting April 1, 2019, medically complex for the developmentally disabled facilities must be reimbursed an exceptional care per diem rate, instead of the base rate, for services to residents with complex or extensive medical needs. Exceptional care per diem rates must be paid for the conditions or services specified under subsection (f) at the following per diem rates: Tier 1 $326, Tier 2 $546, and Tier 3 $735.

(d) For ~~To qualify for the per diem rate of $669 for clinically complex~~ residents on a ventilator pursuant to subsection (c) or subsection (f), facilities shall have a policy documenting their method of routine assessment of a resident's weaning potential with interventions implemented

noted in the resident's medical record.

(e) For services provided prior to April 1, 2019 and for ~~For~~ the purposes of this Section, a resident is considered clinically complex if the resident requires at least one of the following medical services:

(1) Tracheostomy care with dependence on mechanical ventilation for a minimum of 6 hours each day.

(2) Tracheostomy care requiring suctioning at least every 6 hours, room air mist or oxygen as needed, and dependence on one of the treatment procedures listed under paragraph (4) excluding the procedure listed in subparagraph (A) of paragraph (4).

(3) Total parenteral nutrition or other intravenous nutritional support and one of the treatment procedures listed under paragraph (4).

(4) The following treatment procedures apply to the conditions in paragraphs (2) and (3) of this subsection:

(A) Intermittent suctioning at least every 8 hours and room air mist or oxygen as needed.

(B) Continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent via a peripheral or central line, without continuous infusion.

(C) Peritoneal dialysis treatments requiring at

least 4 exchanges every 24 hours.

(D) Tube feeding via nasogastric or gastrostomy tube.

(E) Other medical technologies required continuously, which in the opinion of the attending physician require the services of a professional nurse.

(f) Complex or extensive medical needs for exceptional care reimbursement. The conditions and services used for the purposes of this Section have the same meanings as ascribed to those conditions and services under the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) and specified in the most recent manual. Instead of submitting minimum data set assessments to the Department, medically complex for the developmentally disabled facilities must document within each resident's medical record the conditions or services using the minimum data set documentation standards and requirements to qualify for exceptional care reimbursement.

(1) Tier 1 reimbursement is for residents who are receiving at least 51% of their caloric intake via a feeding tube.

(2) Tier 2 reimbursement is for residents who are receiving tracheostomy care without a ventilator.

(3) Tier 3 reimbursement is for residents who are receiving tracheostomy care and ventilator care.

(g) For dates of services starting April 1, 2019,

reimbursement calculations and direct payment for services provided by medically complex for the developmentally disabled facilities are the responsibility of the Department of Healthcare and Family Services instead of the Department of Human Services. Appropriations for medically complex for the developmentally disabled facilities must be shifted from the Department of Human Services to the Department of Healthcare and Family Services. Nothing in this Section prohibits the Department of Healthcare and Family Services from paying more than the rates specified in this Section. The rates in this Section must be interpreted as a minimum amount. Any reimbursement increases applied to providers licensed under the ID/DD Community Care Act must also be applied in an equivalent manner to medically complex for the developmentally disabled facilities.

(h) The Department of Healthcare and Family Services shall pay the rates in effect on March 31, 2019 until the changes made to this Section by this amendatory Act of the 100th General Assembly have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

(i) The Department of Healthcare and Family Services may adopt rules as allowed by the Illinois Administrative Procedure Act to implement this Section; however, the requirements of this Section must be implemented by the Department of Healthcare and Family Services even if the Department of

Healthcare and Family Services has not adopted rules by the implementation date of April 1, 2019.

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

(305 ILCS 5/5-5.07 new)

Sec. 5-5.07. Inpatient psychiatric stay; DCFS per diem rate. The Department of Children and Family Services shall pay the DCFS per diem rate for inpatient psychiatric stay at a free-standing psychiatric hospital effective the 11th day when a child is in the hospital beyond medical necessity, and the parent or caregiver has denied the child access to the home and has refused or failed to make provisions for another living arrangement for the child or the child's discharge is being delayed due to a pending inquiry or investigation by the Department of Children and Family Services. This Section is repealed 6 months after the effective date of this amendatory Act of the 100th General Assembly.

(305 ILCS 5/5-30.8 new)

Sec. 5-30.8. Managed care organization rate transparency.

(a) For the establishment of Managed care organization (MCO) capitated base rate payments from the State, including, but not limited to: (i) hospital fee schedule reforms and updates, (ii) rates related to a single State-mandated preferred drug list, (iii) rate updates related to the State's preferred drug list, (iv) inclusion of coverage for children

with special needs, (v) inclusion of coverage for children within the child welfare system, (vi) annual MCO capitated rates, and (vii) any retroactive provider fee schedule adjustments or other changes required by legislation or other actions, the Department of Healthcare and Family Services shall implement a capitation base rate setting process beginning on the effective date of this amendatory Act of the 100th General Assembly which shall include all of the following elements of transparency:

(1) The Department shall include participating MCOs and a statewide trade association representing a majority of participating MCOs in meetings to discuss the impact to base capitation rates as a result of any new or updated hospital fee schedules or other provider fee schedules. Additionally, the Department shall share any data or reports used to develop MCO capitation rates with participating MCOs. This data shall be comprehensive enough for MCO actuaries to recreate and verify the accuracy of the capitation base rate build-up.

(2) The Department shall not limit the number of experts that each MCO is allowed to bring to the draft capitation base rate meeting or the final capitation base rate review meeting. Draft and final capitation base rate review meetings shall be held in at least 2 locations.

(3) The Department and its contracted actuary shall meet with all participating MCOs simultaneously and

together along with consulting actuaries contracted with statewide trade association representing a majority of Medicaid health plans at the request of the plans. Participating MCOs shall additionally, at their request, be granted individual capitation rate development meetings with the Department.

(4) Any quality incentive or other incentive withholding of any portion of the actuarially certified capitation rates must be budget-neutral. The entirety of any aggregate withheld amounts must be returned to the MCOs in proportion to their performance on the relevant performance metric. No amounts shall be returned to the Department if all performance measures are not achieved to the extent allowable by federal law and regulations.

(5) Upon request, the Department shall provide written responses to questions regarding MCO capitation base rates, the capitation base development methodology, and MCO capitation rate data, and all other requests regarding capitation rates from MCOs. Upon request, the Department shall also provide to the MCOs materials used in incorporating provider fee schedules into base capitation rates.

(b) For the development of capitation base rates for new capitation rate years:

(1) The Department shall take into account emerging experience in the development of the annual MCO capitation

base rates, including, but not limited to, current-year cost and utilization trends observed by MCOs in an actuarially sound manner and in accordance with federal law and regulations.

(2) No later than January 1 of each year, the Department shall release an agreed upon annual calendar that outlines dates for capitation rate setting meetings for that year. The calendar shall include at least the following meetings and deadlines:

(A) An initial meeting for the Department to review MCO data and draft rate assumptions to be used in the development of capitation base rates for the following year.

(B) A draft rate meeting after the Department provides the MCOs with the draft capitated base rates to discuss, review, and seek feedback regarding the draft capitation base rates.

(3) Prior to the submission of final capitation rates to the federal Centers for Medicare and Medicaid Services, the Department shall provide the MCOs with a final actuarial report including the final capitation base rates for the following year and subsequently conduct a final capitation base review meeting. Final capitation rates shall be marked final.

(c) For the development of capitation base rates reflecting policy changes:

(1) Unless contrary to federal law and regulation, the Department must provide notice to MCOs of any significant operational policy change no later than 60 days prior to the effective date of an operational policy change in order to give MCOs time to prepare for and implement the operational policy change and to ensure that the quality and delivery of enrollee health care is not disrupted. "Operational policy change" means a change to operational requirements such as reporting formats, encounter submission definitional changes, or required provider interfaces made at the sole discretion of the Department and not required by legislation with a retroactive effective date. Nothing in this Section shall be construed as a requirement to delay or prohibit implementation of policy changes that impact enrollee benefits as determined in the sole discretion of the Department.

(2) No later than 60 days after the effective date of the policy change or program implementation, the Department shall meet with the MCOs regarding the initial data collection needed to establish capitation base rates for the policy change. Additionally, the Department shall share with the participating MCOs what other data is needed to estimate the change and the processes for collection of that data that shall be utilized to develop capitation base rates.

(3) No later than 60 days after the effective date of

the policy change or program implementation, the Department shall meet with MCOs to review data and the Department's written draft assumptions to be used in development of capitation base rates for the policy change, and shall provide opportunities for questions to be asked and answered.

(4) No later than 60 days after the effective date of the policy change or program implementation, the Department shall provide the MCOs with draft capitation base rates and shall also conduct a draft capitation base rate meeting with MCOs to discuss, review, and seek feedback regarding the draft capitation base rates.

(d) For the development of capitation base rates for retroactive policy or fee schedule changes:

(1) The Department shall meet with the MCOs regarding the initial data collection needed to establish capitation base rates for the policy change. Additionally, the Department shall share with the participating MCOs what other data is needed to estimate the change and the processes for collection of the data that shall be utilized to develop capitation base rates.

(2) The Department shall meet with MCOs to review data and the Department's written draft assumptions to be used in development of capitation base rates for the policy change. The Department shall provide opportunities for questions to be asked and answered.

(3) The Department shall provide the MCOs with draft capitated rates and shall also conduct a draft rate meeting with MCOs to discuss, review, and seek feedback regarding the draft capitation base rates.

(4) The Department shall inform MCOs no less than quarterly of upcoming benefit and policy changes to the Medicaid program.

(e) Meetings of the group established to discuss Medicaid capitation rates under this Section shall be closed to the public and shall not be subject to the Open Meetings Act. Records and information produced by the group established to discuss Medicaid capitation rates under this Section shall be confidential and not subject to the Freedom of Information Act.

(305 ILCS 5/5A-16)

Sec. 5A-16. State fiscal year 2019 implementation protection.

(a) To preserve access to hospital services and to ensure continuity of payments and stability of access to hospital services, it is the intent of the General Assembly that there not be a gap in payments to hospitals while the changes authorized under Public Act 100-581 ~~this amendatory Act of the 100th General Assembly~~ are being reviewed by the federal Centers for Medicare and Medicaid Services and implemented by the Department. Therefore, pending the review and approval of the changes to the assessment and hospital reimbursement

methodologies authorized under Public Act 100-581 ~~this amendatory Act of the 100th General Assembly~~ by the federal Centers for Medicare and Medicaid Services and the final implementation of such program by the Department, the Department shall take all actions necessary to continue the reimbursement methodologies and payments to hospitals that are changed under Public Act 100-581 ~~this amendatory Act of the 100th General Assembly~~, as they are in effect on June 30, 2018, until the first day of the second month after the new and revised methodologies and payments authorized under Public Act 100-581 ~~this amendatory Act of the 100th General Assembly~~ are effective and implemented by the Department. Such actions by the Department shall include, but not be limited to, requesting prior to June 15, 2018 the extension of any federal approval of the currently approved payment methodologies contained in Illinois' Medicaid State Plan while the federal Centers for Medicare and Medicaid Services reviews the proposed changes authorized under Public Act 100-581 ~~this amendatory Act of the 100th General Assembly~~.

(b) Notwithstanding any other provision of this Code, if the federal Centers for Medicare and Medicaid Services should approve the continuation of the reimbursement methodologies and payments to hospitals under Sections ~~5A-12.2, 5A-12.4,~~ 5A-12.5 and ~~, and Section~~ 14-12, as they are in effect on June 30, 2018, until the new and revised methodologies and payments authorized under Sections 5A-12.6 and ~~Section~~ 14-12 of this

Code ~~amendatory Act of the 100th General Assembly~~ are federally approved, then the reimbursement methodologies and payments to hospitals under Sections 5A-12.2, 5A-12.4, 5A-12.5, and 14-12, and the assessments imposed under Section 5A-2, as they are in effect on June 30, 2018, shall continue until the effective date of the new and revised methodologies and payments, which shall be the first day of the second month following the date of approval by the federal Centers for Medicare and Medicaid Services.

(c) Notwithstanding any other provision of this Code, if by July 11, 2018 the federal Centers for Medicare and Medicaid Services has neither approved the changes authorized under Public Act 100-581 nor has formally approved an extension of the reimbursement methodologies and payments to hospitals under Sections 5A-12.5 and 14-12 as they are in effect on June 30, 2018, then the following shall apply:

(1) all reimbursement methodologies and payments for hospital services authorized under Sections 5A-12.2, 5A-12.4, and 5A-12.5 in effect on June 30, 2018 shall continue subject to the availability of federal matching funds for such expenditures and subject to the provisions of subsection (c) of Section 5A-15; and

(2) all supplemental payments to hospitals authorized in Illinois' Medicaid State Plan in effect on June 30, 2018, which are scheduled to terminate under Illinois' Medicaid State Plan on June 30, 2018, shall continue

subject to the availability of federal matching funds for such expenditures; and

(3) all assessments imposed under Section 5A-2, as they are in effect on June 30, 2018, shall continue.

Notwithstanding any other provision in this subsection, the Department shall make monthly advance payments to any safety-net hospital or critical access hospital requesting such advance payments in an amount, as requested by the hospital, provided that the total monthly payments to the hospital under this subsection shall not exceed 1/12th of the payments the hospital would have received under Sections 5A-12.2, 5A-12.4, and 5A-12.5 and subsections (d) and (f) of Section 14-12.

Notwithstanding any other provision in this subsection, the Department may make monthly advance payments to a hospital requesting such advance payments in an amount, as requested by the hospital, provided that the total monthly payments to the hospital under this subsection shall not exceed 1/12th of the payments the hospital would have received under Sections 5A-12.2, 5A-12.4, and 5A-12.5 and subsections (d) and (f) of Section 14-12.

Payments under this subsection shall be made regardless of federal approval for federal financial participation under Title XIX or XXI of the federal Social Security Act.

As used in this subsection, "safety-net hospital" means a hospital as defined in Section 5-5e.1 for Rate Year 2017 or an

Illinois hospital that meets the criteria in paragraphs (2) and (3) of subsection (a) of Section 5-5e.1 for Rate Year 2017.

As used in this subsection, "critical access hospital" means a hospital that has such status as of June 30, 2018.

The changes authorized under this subsection shall continue, on the same time schedule as otherwise authorized under this Article, until the effective date of the new and revised methodologies and payments under Public Act 100-581, which shall be the first day of the second month following the date of approval by the federal Centers for Medicare and Medicaid Services.

(Source: P.A. 100-581, eff. 3-12-18.)

Section 95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

Section 999. Effective date. This Act takes effect upon becoming law.".