HB5248

LRB10118468KTG67916b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB5248

by Rep. Yehiel M. Kalish

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5.2 from Ch. 23, par. 5-5.2
305 ILCS 5/5-30
305 ILCS 5/5F-10

Amends the Illinois Public Aid Code. In provisions concerning payment rates for nursing facilities, provides that a benchmark rate equal to the facility's fee-for-service rate shall be established for any facility receiving payment from a managed care entity for services. Provides that on and after July 1, 2020, no managed care entity shall pay a facility less than the established benchmark rate unless the managed care entity and the facility contractually agree upon a rate different than the established benchmark rate. Requires the benchmark rate to be updated quarterly by the Department of Healthcare and Family Services to recognize any rate adjustments to each facility's fee-for-service rate. Provides that until the State is in compliance with federal deadlines for Medicaid eligibility determinations, the Department must not expand the Medicare-Medicaid Alignment Initiative. Provides that beginning July 1, 2020, or upon federal approval, any enrollee who resides in a facility for more than 90 consecutive days shall no longer be required to enroll with a managed care organization and shall revert to having his or her services covered through a fee-for-service arrangement between the facility and the Department for any services received after 90 consecutive days of service. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Sections 5-5.2, 5-30, and 5F-10 as follows:

(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) Notwithstanding any other provision of law, subject to federal approval, effective July 1, 2019, sufficient funds shall be allocated for changes to rates for facilities licensed under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities for dates of services on and after July 1, 2019: (i) to establish a per diem add-on to the direct care per diem rate not to exceed $70,000,000 annually in the aggregate taking into account federal matching funds for the purpose of addressing the facility's unique staffing needs, adjusted quarterly and distributed by a weighted formula based on Medicaid bed days on the last day of the second quarter preceding the quarter for which the rate is being adjusted; and (ii) in an amount not to exceed $170,000,000 annually in the aggregate taking into account federal matching funds to permit the support component of the nursing facility rate to be updated as follows:

(1) 80%, or $136,000,000, of the funds shall be used to update each facility's rate in effect on June 30, 2019 using the most recent cost reports on file, which have had

a limited review conducted by the Department of Healthcare and Family Services and will not hold up enacting the rate increase, with the Department of Healthcare and Family Services and taking into account subsection (i).

(2) After completing the calculation in paragraph (1), any facility whose rate is less than the rate in effect on June 30, 2019 shall have its rate restored to the rate in effect on June 30, 2019 from the 20% of the funds set aside.

(3) The remainder of the 20%, or $34,000,000, shall be used to increase each facility's rate by an equal percentage.

To implement item (i) in this subsection, facilities shall file quarterly reports documenting compliance with its annually approved staffing plan, which shall permit compliance with Section 3-202.05 of the Nursing Home Care Act. A facility that fails to meet the benchmarks and dates contained in the plan may have its add-on adjusted in the quarter following the quarterly review. Nothing in this Section shall limit the ability of the facility to appeal a ruling of non-compliance and a subsequent reduction to the add-on. Funds adjusted for noncompliance shall be maintained in the Long-Term Care Provider Fund and accounted for separately. At the end of each fiscal year, these funds shall be made available to facilities for special staffing projects.

In order to provide for the expeditious and timely

implementation of the provisions of Public Act 101-10 ~~this amendatory Act of the 101st General Assembly~~, emergency rules to implement any provision of Public Act 101-10 ~~this amendatory Act of the 101st General Assembly~~ may be adopted in accordance with this subsection by the agency charged with administering that provision or initiative. The agency shall simultaneously file emergency rules and permanent rules to ensure that there is no interruption in administrative guidance. The 150-day limitation of the effective period of emergency rules does not apply to rules adopted under this subsection, and the effective period may continue through June 30, 2021. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection. The adoption of emergency rules authorized by this subsection is deemed to be necessary for the public interest, safety, and welfare.

(k) ~~(j)~~ During the first quarter of State Fiscal Year 2020, the Department of Healthcare of Family Services must convene a technical advisory group consisting of members of all trade associations representing Illinois skilled nursing providers to discuss changes necessary with federal implementation of Medicare's Patient-Driven Payment Model. Implementation of Medicare's Patient-Driven Payment Model shall, by September 1, 2020, end the collection of the MDS data that is necessary to maintain the current RUG-IV Medicaid payment methodology. The technical advisory group must consider a revised reimbursement methodology that takes into account transparency,

accountability, actual staffing as reported under the federally required Payroll Based Journal system, changes to the minimum wage, adequacy in coverage of the cost of care, and a quality component that rewards quality improvements.

(l) Benchmark rate. For any facility receiving payment from a managed care entity for services, a benchmark rate equal to the facility's fee-for-service rate shall be established. On and after July 1, 2020, no managed care entity shall pay a facility less than the established benchmark rate unless the managed care entity and the facility contractually agree upon a rate different than the established benchmark rate. The benchmark rate shall be updated quarterly by the Department to recognize any rate adjustments to each facility's fee-for-service rate.

(Source: P.A. 101-10, eff. 6-5-19; 101-348, eff. 8-9-19; revised 9-18-19.)

(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 January 25, 2011 (the effective date of Public Act 96-1501).

(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 Public Act 96-1501. 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 June 14, 2012 (the effective date of Public Act 97-689) 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.

(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.

(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) Unless otherwise required by federal law, Medicaid Managed Care Entities and their respective business associates shall not disclose, directly or indirectly, including by

sending a bill or explanation of benefits, information concerning the sensitive health services received by enrollees of the Medicaid Managed Care Entity to any person other than covered entities and business associates, which may receive, use, and further disclose such information solely for the purposes permitted under applicable federal and State laws and regulations if such use and further disclosure satisfies all applicable requirements of such laws and regulations. The Medicaid Managed Care Entity or its respective business associates may disclose information concerning the sensitive health services if the enrollee who received the sensitive health services requests the information from the Medicaid Managed Care Entity or its respective business associates and authorized the sending of a bill or explanation of benefits. Communications including, but not limited to, statements of care received or appointment reminders either directly or indirectly to the enrollee from the health care provider, health care professional, and care coordinators, remain permissible. Medicaid Managed Care Entities or their respective business associates may communicate directly with their enrollees regarding care coordination activities for those enrollees.

For the purposes of this subsection, the term "Medicaid Managed Care Entity" includes Care Coordination Entities, Accountable Care Entities, Managed Care Organizations, and Managed Care Community Networks.

For purposes of this subsection, the term "sensitive health services" means mental health services, substance abuse treatment services, reproductive health services, family planning services, services for sexually transmitted infections and sexually transmitted diseases, and services for sexual assault or domestic abuse. Services include prevention, screening, consultation, examination, treatment, or follow-up.

For purposes of this subsection, "business associate", "covered entity", "disclosure", and "use" have the meanings ascribed to those terms in 45 CFR 160.103.

Nothing in this subsection shall be construed to relieve a Medicaid Managed Care Entity or the Department of any duty to report incidents of sexually transmitted infections to the Department of Public Health or to the local board of health in accordance with regulations adopted under a statute or ordinance or to report incidents of sexually transmitted infections as necessary to comply with the requirements under Section 5 of the Abused and Neglected Child Reporting Act or as otherwise required by State or federal law.

The Department shall create policy in order to implement the requirements in this subsection.

(j) Managed Care Entities (MCEs), including MCOs and all other care coordination organizations, shall develop and maintain a written language access policy that sets forth the standards, guidelines, and operational plan to ensure language appropriate services and that is consistent with the standard

of meaningful access for populations with limited English proficiency. The language access policy shall describe how the MCEs will provide all of the following required services:

(1) Translation (the written replacement of text from one language into another) of all vital documents and forms as identified by the Department.

(2) Qualified interpreter services (the oral communication of a message from one language into another by a qualified interpreter).

(3) Staff training on the language access policy, including how to identify language needs, access and provide language assistance services, work with interpreters, request translations, and track the use of language assistance services.

(4) Data tracking that identifies the language need.

(5) Notification to participants on the availability of language access services and on how to access such services.

(k) The Department shall actively monitor the contractual relationship between Managed Care Organizations (MCOs) and any dental administrator contracted by an MCO to provide dental services. The Department shall adopt appropriate dental Healthcare Effectiveness Data and Information Set (HEDIS) measures and shall include the Annual Dental Visit (ADV) HEDIS measure in its Health Plan Comparison Tool and Illinois Medicaid Plan Report Card that is available on the Department's

website for enrolled individuals.

The Department shall collect from each MCO specific information about the types of contracted, broad-based care coordination occurring between the MCO and any dental administrator, including, but not limited to, pregnant women and diabetic patients in need of oral care.

(l) Until the State is in compliance with the federal deadlines for eligibility determinations under 42 U.S.C. 1396a(a)(8) and 42 CFR 435, the Department of Healthcare and Family Services must not expand the Medicare-Medicaid Alignment Initiative under Article V-F.

(Source: P.A. 99-106, eff. 1-1-16; 99-181, eff. 7-29-15; 99-566, eff. 1-1-17; 99-642, eff. 7-28-16; 100-587, eff. 6-4-18.)

(305 ILCS 5/5F-10)

Sec. 5F-10. Scope. This Article applies to policies and contracts amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 98th General Assembly for the nursing home component of the Medicare-Medicaid Alignment Initiative and the Managed Long-Term Services and Support Program. This Article does not diminish a managed care organization's duties and responsibilities under other federal or State laws or rules adopted under those laws and the 3-way Medicare-Medicaid Alignment Initiative contract and the Managed Long-Term

Services and Support Program contract.

Beginning July 1, 2020, or upon federal approval, any enrollee who resides in a facility for more than 90 consecutive days shall no longer be required to enroll with a managed care organization and shall revert to having his or her services covered through a fee-for-service arrangement between the facility and the Department for any services received after 90 consecutive days of service.

(Source: P.A. 98-651, eff. 6-16-14; 99-719, eff. 1-1-17.)

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