AN ACT concerning public aid.

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

Article 1

Section 1-5. The Illinois Public Aid Code is amended by adding Article V-F as follows:

(305 ILCS 5/Art. V-F heading new)

ARTICLE V-F. MEDICARE-MEDICAID ALIGNMENT INITIATIVE (MMAI) NURSING HOME RESIDENTS' MANAGED CARE RIGHTS LAW

(305 ILCS 5/5F-1 new)

Sec. 5F-1. Short title. This Article may be referred to as the Medicare-Medicaid Alignment Initiative (MMAI) Nursing Home Residents' Managed Care Rights Law.

(305 ILCS 5/5F-5 new)

Sec. 5F-5. Findings. The General Assembly finds that elderly Illinoisans residing in a nursing home have the right to:

(1) quality health care regardless of the payer;

(2) receive medically necessary care prescribed by

their doctors;

(3) a simple appeal process when care is denied; and

(4) make decisions about their care and where they receive it.

(305 ILCS 5/5F-10 new)

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. 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.

(305 ILCS 5/5F-15 new)

Sec. 5F-15. Definitions. As used in this Article:

"Appeal" means any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services, such that a delay would adversely affect the health of the enrollee or on any amounts the enrollee must pay for a service, as defined under 42 CFR 422.566(b). These procedures include reconsiderations by the

managed care organization and, if necessary, an independent review entity as provided by the Health Carrier External Review Act, hearings before administrative law judges, review by the Medicare Appeals Council, and judicial review.

"Demonstration Project" means the nursing home component of the Medicare-Medicaid Alignment Initiative Demonstration Project.

"Department" means the Department of Healthcare and Family Services.

"Enrollee" means an individual who resides in a nursing home or is qualified to be admitted to a nursing home and is enrolled with a managed care organization participating in the Demonstration Project.

"Health care services" means the diagnosis, treatment, and prevention of disease and includes medication, primary care, nursing or medical care, mental health treatment, psychiatric rehabilitation, memory loss services, physical, occupational, and speech rehabilitation, enhanced care, medical supplies and equipment and the repair of such equipment, and assistance with activities of daily living.

"Managed care organization" or "MCO" means an entity that meets the definition of health maintenance organization as defined in the Health Maintenance Organization Act, is licensed, regulated and in good standing with the Department of Insurance, and is authorized to participate in the nursing home component of the Medicare-Medicaid Alignment Initiative

Demonstration Project by a 3-way contract with the Department of Healthcare and Family Services and the Centers for Medicare and Medicaid Services.

"Medical professional" means a physician, physician assistant, or nurse practitioner.

"Medically necessary" means health care services that a medical professional, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms, and that are: (i) in accordance with the generally accepted standards of medical practice; (ii) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and (iii) not primarily for the convenience of the patient, a medical professional, other health care provider, caregiver, family member, or other interested party.

"Nursing home" means a facility licensed under the Nursing Home Care Act.

"Nurse practitioner" means an individual properly licensed as a nurse practitioner under the Nurse Practice Act.

"Physician" means an individual licensed to practice in all branches of medicine under the Medical Practice Act of 1987.

"Physician assistant" means an individual properly licensed under the Physician Assistant Practice Act of 1987.

"Resident" means an enrollee who is receiving personal or

medical care, including, but not limited to, mental health treatment, psychiatric rehabilitation, physical rehabilitation, and assistance with activities of daily living, from a nursing home.

"RAI Manual" means the most recent Resident Assessment Instrument Manual, published by the Centers for Medicare and Medicaid Services.

"Resident's representative" means a person designated in writing by a resident to be the resident's representative or the resident's guardian, as described by the Nursing Home Care Act.

"SNFist" means a medical professional specializing in the care of individuals residing in nursing homes employed by or under contract with a MCO.

"Transition period" means a period of time immediately following enrollment into the Demonstration Project or an enrollee's movement from one managed care organization to another managed care organization or one care setting to another care setting.

(305 ILCS 5/5F-20 new)

Sec. 5F-20. Network adequacy.

(a) Every managed care organization shall allow every nursing home in its service area an opportunity to be a network contracted facility at the plan's standard terms, conditions, and rates. Either party may opt to limit the contract to

existing residents only.

(b) With the exception of subsection (c) of this Section, a managed care organization shall only terminate or refuse to renew a contract with a nursing home if the nursing home fails to meet quality standards if the following conditions are met:

(1) the quality standards are made known to the nursing home;

(2) the quality standards can be objectively measured through data;

(3) the nursing home is measured on at least a year's worth of performance;

(4) a nursing home that the MCO has determined did not meet a quality standard has the opportunity to contest that determination by challenging the accuracy or the measurement of the data through an arbitration process agreed to by contract; and

(5) the Department may attempt to mediate a dispute prior to arbitration.

(c) A managed care organization may terminate or refuse to renew a contract with a nursing home for a material breach of the contract, including, but not limited to, failure to grant reasonable and timely access to the MCO's care coordinators, SNFists and other providers, termination from the Medicare or Medicaid program, or revocation of license.

(305 ILCS 5/5F-25 new)

Sec. 5F-25. Care coordination. Care coordination provided to all enrollees in the Demonstration Project shall conform to the following requirements:

(1) care coordination services shall be enrollee-driven and person-centered;

(2) all enrollees in the Demonstration Project shall have the right to receive health care services in the care setting of their choice, except as permitted by Part 4 of Article III of the Nursing Home Care Act with respect to involuntary transfers and discharges; and

(3) decisions shall be based on the enrollee's best interests.

(305 ILCS 5/5F-30 new)

Sec. 5F-30. Continuity of care. When a nursing home resident first transitions to a managed care organization from the fee-for-service system or from another managed care organization, the managed care organization shall honor the existing care plan and any necessary changes to that care plan until the MCO has completed a comprehensive assessment and new care plan, to the extent such services are covered benefits under the contract, which shall be consistent with the requirements of the RAI Manual.

When an enrollee of a managed care organization is moving from a community setting to a nursing home, and the MCO is properly notified of the proposed admission by a network

nursing home, and the managed care organization fails to participate in developing a care plan within the time frames required by nursing home regulations, the MCO must honor a care plan developed by the nursing home until the MCO has completed a comprehensive assessment and a new care plan to the extent such services are covered benefits under the contract, consistent with the requirements of the RAI Manual.

A nursing home shall have the ability to refuse admission of an enrollee for whom care is required that the nursing home determines is outside the scope of its license and healthcare capabilities.

(305 ILCS 5/5F-32 new)

Sec. 5F-32. Non-emergency prior approval and appeal.

(a) MCOs must have a method of receiving prior approval requests 24 hours a day, 7 days a week, 365 days a year for nursing home residents. If a response is not provided within 24 hours of the request and the nursing home is required by regulation to provide a service because a physician ordered it, the MCO must pay for the service if it is a covered service under the MCO's contract in the Demonstration Project, provided that the request is consistent with the policies and procedures of the MCO.

In a non-emergency situation, notwithstanding any provisions in State law to the contrary, in the event a resident's physician orders a service, treatment, or test that

is not approved by the MCO, the physician and the provider may utilize an expedited appeal to the MCO.

If an enrollee or provider requests an expedited appeal pursuant to 42 CFR 438.410, the MCO shall notify the enrollee or provider within 24 hours after the submission of the appeal of all information from the enrollee or provider that the MCO requires to evaluate the appeal. The MCO shall render a decision on an expedited appeal within 24 hours after receipt of the required information.

(b) While the appeal is pending or if the ordered service, treatment, or test is denied after appeal, the Department of Public Health may not cite the nursing home for failure to provide the ordered service, treatment, or test. The nursing home shall not be liable or responsible for an injury in any regulatory proceeding for the following:

(1) failure to follow the appealed or denied order; or

(2) injury to the extent it was caused by the delay or failure to perform the appealed or denied service, treatment, or test.

Provided however, a nursing home shall continue to monitor, document, and ensure the patient's safety. Nothing in this subsection (b) is intended to otherwise change the nursing home's existing obligations under State and federal law to appropriately care for its residents.

(305 ILCS 5/5F-35 new)

Sec. 5F-35. Reimbursement. The Department shall provide each managed care organization with the quarterly facility-specific RUG-IV nursing component per diem along with any add-ons for enhanced care services, support component per diem, and capital component per diem effective for each nursing home under contract with the managed care organization.

(305 ILCS 5/5F-40 new)

Sec. 5F-40. Contractual requirements.

(a) Every contract shall contain a clause for termination consistent with the Managed Care Reform and Patient Rights Act providing nursing homes the ability to terminate the contract.

(b) All changes to the contract by the MCO shall be preceded by 30 days' written notice sent to the nursing home.

(305 ILCS 5/5F-45 new)

Sec. 5F-45. Prohibition. No managed care organization or contract shall contain any provision, policy, or procedure that limits, restricts, or waives any rights set forth in this Article or is expressly prohibited by this Article. Any such policy or procedure is void and unenforceable.

Section 1-10. The Health Maintenance Organization Act is amended by changing Section 1-2 as follows:

(215 ILCS 125/1-2) (from Ch. 111 1/2, par. 1402)

Sec. 1-2. Definitions. As used in this Act, unless the context otherwise requires, the following terms shall have the meanings ascribed to them:

(1) "Advertisement" means any printed or published material, audiovisual material and descriptive literature of the health care plan used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards and similar displays; and any descriptive literature or sales aids of all kinds disseminated by a representative of the health care plan for presentation to the public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters and prepared sales presentations.

(2) "Director" means the Director of Insurance.

(3) "Basic health care services" means emergency care, and inpatient hospital and physician care, outpatient medical services, mental health services and care for alcohol and drug abuse, including any reasonable deductibles and co-payments, all of which are subject to the limitations described in Section 4-20 of this Act and as determined by the Director pursuant to rule.

(4) "Enrollee" means an individual who has been enrolled in a health care plan.

(5) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled in exchange for a per capita prepaid sum.

(6) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group.

(7) "Health care plan" means any arrangement whereby any organization undertakes to provide or arrange for and pay for or reimburse the cost of basic health care services, excluding any reasonable deductibles and copayments, from providers selected by the Health Maintenance Organization and such arrangement consists of arranging for or the provision of such health care services, as distinguished from mere indemnification against the cost of such services, except as otherwise authorized by Section 2-3 of this Act, on a per capita prepaid basis, through insurance or otherwise. A "health care plan" also includes any arrangement whereby an organization undertakes to provide or arrange for or pay for or reimburse the cost of any health care service for persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act through providers selected by the organization and the arrangement consists of making provision for the delivery of health care services, as distinguished from mere indemnification. A "health care plan" also includes any arrangement pursuant to Section 4-17. Nothing in this definition, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

(8) "Health care services" means any services included in

the furnishing to any individual of medical or dental care, or the hospitalization or incident to the furnishing of such care or hospitalization as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury.

(9) "Health Maintenance Organization" means any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers.

(10) "Net worth" means admitted assets, as defined in Section 1-3 of this Act, minus liabilities.

(11) "Organization" means any insurance company, a nonprofit corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act, or a corporation organized under the laws of this or another state for the purpose of operating one or more health care plans and doing no business other than that of a Health Maintenance Organization or an insurance company. "Organization" shall also mean the University of Illinois Hospital as defined in the University of Illinois Hospital Act or a unit of local government health system operating within a county with a population of 3,000,000 or more.

(12) "Provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, or other person which is licensed or otherwise authorized to furnish

health care services and also includes any other entity that arranges for the delivery or furnishing of health care service.

(13) "Producer" means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment.

(14) "Per capita prepaid" means a basis of prepayment by which a fixed amount of money is prepaid per individual or any other enrollment unit to the Health Maintenance Organization or for health care services which are provided during a definite time period regardless of the frequency or extent of the services rendered by the Health Maintenance Organization, except for copayments and deductibles and except as provided in subsection (f) of Section 5-3 of this Act.

(15) "Subscriber" means a person who has entered into a contractual relationship with the Health Maintenance Organization for the provision of or arrangement of at least basic health care services to the beneficiaries of such contract.

(Source: P.A. 97-1148, eff. 1-24-13.)

Section 1-15. The Managed Care Reform and Patient Rights Act is amended by changing Section 10 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions:

"Adverse determination" means a determination by a health

care plan under Section 45 or by a utilization review program under Section 85 that a health care service is not medically necessary.

"Clinical peer" means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

"Department" means the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

"Emergency medical screening examination" means a medical screening examination and evaluation by a physician licensed to practice medicine in all its branches, or to the extent permitted by applicable laws, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches to determine whether the need for emergency services exists.

"Emergency services" means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

"Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

"Health care plan" means a plan<u>, including, but not limited to, a health maintenance organization, a managed care community network as defined in the Illinois Public Aid Code, or an accountable care entity as defined in the Illinois Public Aid Code that receives capitated payments to cover medical services from the Department of Healthcare and Family Services,</u> that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

For purposes of this definition, "health care plan" shall not include the following:

(1) indemnity health insurance policies including those using a contracted provider network;

(2) health care plans that offer only dental or only vision coverage;

(3) preferred provider administrators, as defined in Section 370g(g) of the Illinois Insurance Code;

(4) employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974;

(5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

(6) not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.

"Health care professional" means a physician, a registered professional nurse, or other individual appropriately licensed or registered to provide health care services.

"Health care provider" means any physician, hospital facility, <u>facility licensed under the Nursing Home Care Act,</u> or other person that is licensed or otherwise authorized to deliver health care services. Nothing in this Act shall be

construed to define Independent Practice Associations or Physician-Hospital Organizations as health care providers.

"Health care services" means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury including home health and pharmaceutical services and products.

"Medical director" means a physician licensed in any state to practice medicine in all its branches appointed by a health care plan.

"Person" means a corporation, association, partnership, limited liability company, sole proprietorship, or any other legal entity.

"Physician" means a person licensed under the Medical Practice Act of 1987.

"Post-stabilization medical services" means health care services provided to an enrollee that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.

"Stabilization" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable

medical probability, that no material deterioration of the condition is likely to result.

"Utilization review" means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

"Utilization review program" means a program established by a person to perform utilization review.

(Source: P.A. 91-617, eff. 1-1-00.)

Article 5

Section 5-5. The Illinois Health Facilities Planning Act is amended by changing Sections 3 and 12 as follows:

(20 ILCS 3960/3) (from Ch. 111 1/2, par. 1153)

(Section scheduled to be repealed on December 31, 2019)

Sec. 3. Definitions. As used in this Act:

"Health care facilities" means and includes the following facilities, organizations, and related persons:

1. An ambulatory surgical treatment center required to be licensed pursuant to the Ambulatory Surgical Treatment Center Act;

2. An institution, place, building, or agency required to be licensed pursuant to the Hospital Licensing Act;

3. Skilled and intermediate long term care facilities licensed under the Nursing Home Care Act;

3.5. Skilled and intermediate care facilities licensed under the ID/DD Community Care Act;

3.7. Facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013;

4. Hospitals, nursing homes, ambulatory surgical treatment centers, or kidney disease treatment centers maintained by the State or any department or agency thereof;

5. Kidney disease treatment centers, including a free-standing hemodialysis unit required to be licensed under the End Stage Renal Disease Facility Act;

6. An institution, place, building, or room used for the performance of outpatient surgical procedures that is leased, owned, or operated by or on behalf of an out-of-state facility;

7. An institution, place, building, or room used for provision of a health care category of service, including, but not limited to, cardiac catheterization and open heart surgery; and

8. An institution, place, building, or room used for provision of major medical equipment used in the direct clinical diagnosis or treatment of patients, and whose project cost is in excess of the capital expenditure minimum.

This Act shall not apply to the construction of any new facility or the renovation of any existing facility located on

any campus facility as defined in Section 5-5.8b of the Illinois Public Aid Code, provided that the campus facility encompasses 30 or more contiguous acres and that the new or renovated facility is intended for use by a licensed residential facility.

No federally owned facility shall be subject to the provisions of this Act, nor facilities used solely for healing by prayer or spiritual means.

No facility licensed under the Supportive Residences Licensing Act or the Assisted Living and Shared Housing Act shall be subject to the provisions of this Act.

No facility established and operating under the Alternative Health Care Delivery Act as a children's respite care center alternative health care model demonstration program or as an Alzheimer's Disease Management Center alternative health care model demonstration program shall be subject to the provisions of this Act.

A facility designated as a supportive living facility that is in good standing with the program established under Section 5-5.01a of the Illinois Public Aid Code shall not be subject to the provisions of this Act.

This Act does not apply to facilities granted waivers under Section 3-102.2 of the Nursing Home Care Act. However, if a demonstration project under that Act applies for a certificate of need to convert to a nursing facility, it shall meet the licensure and certificate of need requirements in effect as of

the date of application.

This Act does not apply to a dialysis facility that provides only dialysis training, support, and related services to individuals with end stage renal disease who have elected to receive home dialysis. This Act does not apply to a dialysis unit located in a licensed nursing home that offers or provides dialysis-related services to residents with end stage renal disease who have elected to receive home dialysis within the nursing home. The Board, however, may require these dialysis facilities and licensed nursing homes to report statistical information on a quarterly basis to the Board to be used by the Board to conduct analyses on the need for proposed kidney disease treatment centers.

This Act shall not apply to the closure of an entity or a portion of an entity licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act <u>of 2013</u>, or the ID/DD Community Care Act, with the exceptions of facilities operated by a county or Illinois Veterans Homes, that elects to convert, in whole or in part, to an assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act <u>and with the exception of a facility licensed under the Specialized Mental Health Rehabilitation Act of 2013 in connection with a proposal to close a facility and re-establish the facility in another location</u>.

This Act does not apply to any change of ownership of a healthcare facility that is licensed under the Nursing Home

Care Act, the Specialized Mental Health Rehabilitation Act of 2013, or the ID/DD Community Care Act, with the exceptions of facilities operated by a county or Illinois Veterans Homes. Changes of ownership of facilities licensed under the Nursing Home Care Act must meet the requirements set forth in Sections 3-101 through 3-119 of the Nursing Home Care Act.

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional group. Further, this Act shall not apply to physicians or other licensed health care professional's practices where such practices are carried out in a portion of a health care facility under contract with such health care facility by a physician or by other licensed health care professionals, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional groups, unless the entity constructs, modifies, or establishes a health care facility as specifically defined in this Section. This Act shall apply to construction or modification and to establishment by such health care facility of such contracted portion which is subject to facility

licensing requirements, irrespective of the party responsible for such action or attendant financial obligation.

No permit or exemption is required for a facility licensed under the ID/DD Community Care Act prior to the reduction of the number of beds at a facility. If there is a total reduction of beds at a facility licensed under the ID/DD Community Care Act, this is a discontinuation or closure of the facility. However, if a facility licensed under the ID/DD Community Care Act reduces the number of beds or discontinues the facility, that facility must notify the Board as provided in Section 14.1 of this Act.

"Person" means any one or more natural persons, legal entities, governmental bodies other than federal, or any combination thereof.

"Consumer" means any person other than a person (a) whose major occupation currently involves or whose official capacity within the last 12 months has involved the providing, administering or financing of any type of health care facility, (b) who is engaged in health research or the teaching of health, (c) who has a material financial interest in any activity which involves the providing, administering or financing of any type of health care facility, or (d) who is or ever has been a member of the immediate family of the person defined by (a), (b), or (c).

"State Board" or "Board" means the Health Facilities and Services Review Board.

"Construction or modification" means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purposes or for facility administration or operation, or any capital expenditure made by or on behalf of a health care facility which exceeds the capital expenditure minimum; however, any capital expenditure made by or on behalf of a health care facility for (i) the construction or modification of a facility licensed under the Assisted Living and Shared Housing Act or (ii) a conversion project undertaken in accordance with Section 30 of the Older Adult Services Act shall be excluded from any obligations under this Act.

"Establish" means the construction of a health care facility or the replacement of an existing facility on another site or the initiation of a category of service.

"Major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the capital expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act to

meet the requirements of paragraphs (10) and (11) of Section 1861(s) of such Act. In determining whether medical equipment has a value in excess of the capital expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.

"Capital Expenditure" means an expenditure: (A) made by or on behalf of a health care facility (as such a facility is defined in this Act); and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and which exceeds the capital expenditure minimum.

For the purpose of this paragraph, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Unless otherwise interdependent, or submitted as one project by the applicant, components of construction or modification undertaken by means of a single construction contract or financed through the issuance of a single debt instrument shall not be grouped together as one project. Donations of equipment or facilities to a health care

facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

"Capital expenditure minimum" means $11,500,000 for projects by hospital applicants, $6,500,000 for applicants for projects related to skilled and intermediate care long-term care facilities licensed under the Nursing Home Care Act, and $3,000,000 for projects by all other applicants, which shall be annually adjusted to reflect the increase in construction costs due to inflation, for major medical equipment and for all other capital expenditures.

"Non-clinical service area" means an area (i) for the benefit of the patients, visitors, staff, or employees of a health care facility and (ii) not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; news stands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of

structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.

"Areawide" means a major area of the State delineated on a geographic, demographic, and functional basis for health planning and for health service and having within it one or more local areas for health planning and health service. The term "region", as contrasted with the term "subregion", and the word "area" may be used synonymously with the term "areawide".

"Local" means a subarea of a delineated major area that on a geographic, demographic, and functional basis may be considered to be part of such major area. The term "subregion" may be used synonymously with the term "local".

"Physician" means a person licensed to practice in accordance with the Medical Practice Act of 1987, as amended.

"Licensed health care professional" means a person licensed to practice a health profession under pertinent licensing statutes of the State of Illinois.

"Director" means the Director of the Illinois Department of Public Health.

"Agency" means the Illinois Department of Public Health.

"Alternative health care model" means a facility or program authorized under the Alternative Health Care Delivery Act.

"Out-of-state facility" means a person that is both (i) licensed as a hospital or as an ambulatory surgery center under the laws of another state or that qualifies as a hospital or an ambulatory surgery center under regulations adopted pursuant to the Social Security Act and (ii) not licensed under the Ambulatory Surgical Treatment Center Act, the Hospital Licensing Act, or the Nursing Home Care Act. Affiliates of out-of-state facilities shall be considered out-of-state facilities. Affiliates of Illinois licensed health care facilities 100% owned by an Illinois licensed health care facility, its parent, or Illinois physicians licensed to practice medicine in all its branches shall not be considered out-of-state facilities. Nothing in this definition shall be construed to include an office or any part of an office of a physician licensed to practice medicine in all its branches in Illinois that is not required to be licensed under the Ambulatory Surgical Treatment Center Act.

"Change of ownership of a health care facility" means a change in the person who has ownership or control of a health care facility's physical plant and capital assets. A change in ownership is indicated by the following transactions: sale, transfer, acquisition, lease, change of sponsorship, or other means of transferring control.

"Related person" means any person that: (i) is at least 50%

owned, directly or indirectly, by either the health care facility or a person owning, directly or indirectly, at least 50% of the health care facility; or (ii) owns, directly or indirectly, at least 50% of the health care facility.

"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer.

"Freestanding emergency center" means a facility subject to licensure under Section 32.5 of the Emergency Medical Services (EMS) Systems Act.

"Category of service" means a grouping by generic class of various types or levels of support functions, equipment, care, or treatment provided to patients or residents, including, but not limited to, classes such as medical-surgical, pediatrics, or cardiac catheterization. A category of service may include subcategories or levels of care that identify a particular degree or type of care within the category of service. Nothing in this definition shall be construed to include the practice of a physician or other licensed health care professional while functioning in an office providing for the care, diagnosis, or treatment of patients. A category of service that is subject to the Board's jurisdiction must be designated in rules adopted by the Board.

(Source: P.A. 97-38, eff. 6-28-11; 97-277, eff. 1-1-12; 97-813, eff. 7-13-12; 97-980, eff. 8-17-12; 98-414, eff. 1-1-14.)

(20 ILCS 3960/12) (from Ch. 111 1/2, par. 1162)

(Section scheduled to be repealed on December 31, 2019)

Sec. 12. Powers and duties of State Board. For purposes of this Act, the State Board shall exercise the following powers and duties:

(1) Prescribe rules, regulations, standards, criteria, procedures or reviews which may vary according to the purpose for which a particular review is being conducted or the type of project reviewed and which are required to carry out the provisions and purposes of this Act. Policies and procedures of the State Board shall take into consideration the priorities and needs of medically underserved areas and other health care services identified through the comprehensive health planning process, giving special consideration to the impact of projects on access to safety net services.

(2) Adopt procedures for public notice and hearing on all proposed rules, regulations, standards, criteria, and plans required to carry out the provisions of this Act.

(3) (Blank).

(4) Develop criteria and standards for health care facilities planning, conduct statewide inventories of health care facilities, maintain an updated inventory on the Board's web site reflecting the most recent bed and service changes and updated need determinations when new census data become available or new need formulae are adopted, and develop health care facility plans which shall be utilized in the review of

applications for permit under this Act. Such health facility plans shall be coordinated by the Board with pertinent State Plans. Inventories pursuant to this Section of skilled or intermediate care facilities licensed under the Nursing Home Care Act, skilled or intermediate care facilities licensed under the ID/DD Community Care Act, facilities licensed under the Specialized Mental Health Rehabilitation Act, or nursing homes licensed under the Hospital Licensing Act shall be conducted on an annual basis no later than July 1 of each year and shall include among the information requested a list of all services provided by a facility to its residents and to the community at large and differentiate between active and inactive beds.

In developing health care facility plans, the State Board shall consider, but shall not be limited to, the following:

(a) The size, composition and growth of the population of the area to be served;

(b) The number of existing and planned facilities offering similar programs;

(c) The extent of utilization of existing facilities;

(d) The availability of facilities which may serve as alternatives or substitutes;

(e) The availability of personnel necessary to the operation of the facility;

(f) Multi-institutional planning and the establishment of multi-institutional systems where feasible;

(g) The financial and economic feasibility of proposed construction or modification; and

(h) In the case of health care facilities established by a religious body or denomination, the needs of the members of such religious body or denomination may be considered to be public need.

The health care facility plans which are developed and adopted in accordance with this Section shall form the basis for the plan of the State to deal most effectively with statewide health needs in regard to health care facilities.

(5) Coordinate with the Center for Comprehensive Health Planning and other state agencies having responsibilities affecting health care facilities, including those of licensure and cost reporting. Beginning no later than January 1, 2013, the Department of Public Health shall produce a written annual report to the Governor and the General Assembly regarding the development of the Center for Comprehensive Health Planning. The Chairman of the State Board and the State Board Administrator shall also receive a copy of the annual report.

(6) Solicit, accept, hold and administer on behalf of the State any grants or bequests of money, securities or property for use by the State Board or Center for Comprehensive Health Planning in the administration of this Act; and enter into contracts consistent with the appropriations for purposes enumerated in this Act.

(7) The State Board shall prescribe procedures for review,

standards, and criteria which shall be utilized to make periodic reviews and determinations of the appropriateness of any existing health services being rendered by health care facilities subject to the Act. The State Board shall consider recommendations of the Board in making its determinations.

(8) Prescribe, in consultation with the Center for Comprehensive Health Planning, rules, regulations, standards, and criteria for the conduct of an expeditious review of applications for permits for projects of construction or modification of a health care facility, which projects are classified as emergency, substantive, or non-substantive in nature.

Six months after June 30, 2009 (the effective date of Public Act 96-31), substantive projects shall include no more than the following:

(a) Projects to construct (1) a new or replacement facility located on a new site or (2) a replacement facility located on the same site as the original facility and the cost of the replacement facility exceeds the capital expenditure minimum, which shall be reviewed by the Board within 120 days;

(b) Projects proposing a (1) new service within an existing healthcare facility or (2) discontinuation of a service within an existing healthcare facility, which shall be reviewed by the Board within 60 days; or

(c) Projects proposing a change in the bed capacity of

a health care facility by an increase in the total number of beds or by a redistribution of beds among various categories of service or by a relocation of beds from one physical facility or site to another by more than 20 beds or more than 10% of total bed capacity, as defined by the State Board, whichever is less, over a 2-year period.

The Chairman may approve applications for exemption that meet the criteria set forth in rules or refer them to the full Board. The Chairman may approve any unopposed application that meets all of the review criteria or refer them to the full Board.

Such rules shall not abridge the right of the Center for Comprehensive Health Planning to make recommendations on the classification and approval of projects, nor shall such rules prevent the conduct of a public hearing upon the timely request of an interested party. Such reviews shall not exceed 60 days from the date the application is declared to be complete.

(9) Prescribe rules, regulations, standards, and criteria pertaining to the granting of permits for construction and modifications which are emergent in nature and must be undertaken immediately to prevent or correct structural deficiencies or hazardous conditions that may harm or injure persons using the facility, as defined in the rules and regulations of the State Board. This procedure is exempt from public hearing requirements of this Act.

(10) Prescribe rules, regulations, standards and criteria

for the conduct of an expeditious review, not exceeding 60 days, of applications for permits for projects to construct or modify health care facilities which are needed for the care and treatment of persons who have acquired immunodeficiency syndrome (AIDS) or related conditions.

(11) Issue written decisions upon request of the applicant or an adversely affected party to the Board. Requests for a written decision shall be made within 15 days after the Board meeting in which a final decision has been made. A "final decision" for purposes of this Act is the decision to approve or deny an application, or take other actions permitted under this Act, at the time and date of the meeting that such action is scheduled by the Board. The staff of the Board shall prepare a written copy of the final decision and the Board shall approve a final copy for inclusion in the formal record. The Board shall consider, for approval, the written draft of the final decision no later than the next scheduled Board meeting. The written decision shall identify the applicable criteria and factors listed in this Act and the Board's regulations that were taken into consideration by the Board when coming to a final decision. If the Board denies or fails to approve an application for permit or exemption, the Board shall include in the final decision a detailed explanation as to why the application was denied and identify what specific criteria or standards the applicant did not fulfill.

(12) Require at least one of its members to participate in

any public hearing, after the appointment of a majority of the members to the Board.

(13) Provide a mechanism for the public to comment on, and request changes to, draft rules and standards.

(14) Implement public information campaigns to regularly inform the general public about the opportunity for public hearings and public hearing procedures.

(15) Establish a separate set of rules and guidelines for long-term care that recognizes that nursing homes are a different business line and service model from other regulated facilities. An open and transparent process shall be developed that considers the following: how skilled nursing fits in the continuum of care with other care providers, modernization of nursing homes, establishment of more private rooms, development of alternative services, and current trends in long-term care services. The Chairman of the Board shall appoint a permanent Health Services Review Board Long-term Care Facility Advisory Subcommittee that shall develop and recommend to the Board the rules to be established by the Board under this paragraph (15). The Subcommittee shall also provide continuous review and commentary on policies and procedures relative to long-term care and the review of related projects. In consultation with other experts from the health field of long-term care, the Board and the Subcommittee shall study new approaches to the current bed need formula and Health Service Area boundaries to encourage flexibility and innovation in

design models reflective of the changing long-term care marketplace and consumer preferences. The Subcommittee shall evaluate, and make recommendations to the State Board regarding, the buying, selling, and exchange of beds between long-term care facilities within a specified geographic area or drive time. The Board shall file the proposed related administrative rules for the separate rules and guidelines for long-term care required by this paragraph (15) by no later than September 30, 2011. The Subcommittee shall be provided a reasonable and timely opportunity to review and comment on any review, revision, or updating of the criteria, standards, procedures, and rules used to evaluate project applications as provided under Section 12.3 of this Act.

(16) Establish a separate set of rules and guidelines for facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013. An application for the re-establishment of a facility in connection with the relocation of the facility shall not be granted unless the applicant has a contractual relationship with at least one hospital to provide emergency and inpatient mental health services required by facility consumers, and at least one community mental health agency to provide oversight and assistance to facility consumers while living in the facility, and appropriate services, including case management, to assist them to prepare for discharge and reside stably in the community thereafter. No new facilities licensed under the

Specialized Mental Health Rehabilitation Act of 2013 shall be established after the effective date of this amendatory Act of the 98th General Assembly except in connection with the relocation of an existing facility to a new location. An application for a new location shall not be approved unless there are adequate community services accessible to the consumers within a reasonable distance, or by use of public transportation, so as to facilitate the goal of achieving maximum individual self-care and independence. At no time shall the total number of authorized beds under this Act in facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 exceed the number of authorized beds on the effective date of this amendatory Act of the 98th General Assembly.

(Source: P.A. 97-38, eff. 6-28-11; 97-227, eff. 1-1-12; 97-813, eff. 7-13-12; 97-1045, eff. 8-21-13; 97-1115, eff. 8-27-12; 98-414, eff. 1-1-14; 98-463, eff. 8-16-13.)

Section 5-10. The Illinois Public Aid Code is amended by changing Sections 5-5.12 and 5-30 and by adding Section 5-30.1 as follows:

(305 ILCS 5/5-5.12) (from Ch. 23, par. 5-5.12)

Sec. 5-5.12. Pharmacy payments.

(a) Every request submitted by a pharmacy for reimbursement under this Article for prescription drugs provided to a

recipient of aid under this Article shall include the name of the prescriber or an acceptable identification number as established by the Department.

(b) Pharmacies providing prescription drugs under this Article shall be reimbursed at a rate which shall include a professional dispensing fee as determined by the Illinois Department, plus the current acquisition cost of the prescription drug dispensed. The Illinois Department shall update its information on the acquisition costs of all prescription drugs no less frequently than every 30 days. However, the Illinois Department may set the rate of reimbursement for the acquisition cost, by rule, at a percentage of the current average wholesale acquisition cost.

(c) (Blank).

(d) The Department shall review utilization of narcotic medications in the medical assistance program and impose utilization controls that protect against abuse.

(e) When making determinations as to which drugs shall be on a prior approval list, the Department shall include as part of the analysis for this determination, the degree to which a drug may affect individuals in different ways based on factors including the gender of the person taking the medication.

(f) The Department shall cooperate with the Department of Public Health and the Department of Human Services Division of Mental Health in identifying psychotropic medications that, when given in a particular form, manner, duration, or frequency

(including "as needed") in a dosage, or in conjunction with other psychotropic medications to a nursing home resident or to a resident of a facility licensed under the ID/DD Community Care Act, may constitute a chemical restraint or an "unnecessary drug" as defined by the Nursing Home Care Act or Titles XVIII and XIX of the Social Security Act and the implementing rules and regulations. The Department shall require prior approval for any such medication prescribed for a nursing home resident or to a resident of a facility licensed under the ID/DD Community Care Act, that appears to be a chemical restraint or an unnecessary drug. The Department shall consult with the Department of Human Services Division of Mental Health in developing a protocol and criteria for deciding whether to grant such prior approval.

(g) The Department may by rule provide for reimbursement of the dispensing of a 90-day supply of a generic or brand name, non-narcotic maintenance medication in circumstances where it is cost effective.

(g-5) On and after July 1, 2012, the Department may require the dispensing of drugs to nursing home residents be in a 7-day supply or other amount less than a 31-day supply. The Department shall pay only one dispensing fee per 31-day supply.

(h) Effective July 1, 2011, the Department shall discontinue coverage of select over-the-counter drugs, including analgesics and cough and cold and allergy medications.

(h-5) On and after July 1, 2012, the Department shall impose utilization controls, including, but not limited to, prior approval on specialty drugs, oncolytic drugs, drugs for the treatment of HIV or AIDS, immunosuppressant drugs, and biological products in order to maximize savings on these drugs. The Department may adjust payment methodologies for non-pharmacy billed drugs in order to incentivize the selection of lower-cost drugs. For drugs for the treatment of AIDS, the Department shall take into consideration the potential for non-adherence by certain populations, and shall develop protocols with organizations or providers primarily serving those with HIV/AIDS, as long as such measures intend to maintain cost neutrality with other utilization management controls such as prior approval. For hemophilia, the Department shall develop a program of utilization review and control which may include, in the discretion of the Department, prior approvals. The Department may impose special standards on providers that dispense blood factors which shall include, in the discretion of the Department, staff training and education; patient outreach and education; case management; in-home patient assessments; assay management; maintenance of stock; emergency dispensing timeframes; data collection and reporting; dispensing of supplies related to blood factor infusions; cold chain management and packaging practices; care coordination; product recalls; and emergency clinical consultation. The Department may require patients to receive a

comprehensive examination annually at an appropriate provider in order to be eligible to continue to receive blood factor.

(i) 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.

(j) On and after July 1, 2012, the Department shall impose limitations on prescription drugs such that the Department shall not provide reimbursement for more than 4 prescriptions, including 3 brand name prescriptions, for distinct drugs in a 30-day period, unless prior approval is received for all prescriptions in excess of the 4-prescription limit. Drugs in the following therapeutic classes shall not be subject to prior approval as a result of the 4-prescription limit: immunosuppressant drugs, oncolytic drugs, ~~and~~ anti-retroviral drugs<u>, and, on or after July 1, 2014, antipsychotic drugs</u>. <u>On or after July 1, 2014, the Department may exempt children with complex medical needs enrolled in a care coordination entity contracted with the Department to solely coordinate care for such children, if the Department determines that the entity has a comprehensive drug reconciliation program.</u>

(k) No medication therapy management program implemented by the Department shall be contrary to the provisions of the Pharmacy Practice Act.

(l) Any provider enrolled with the Department that bills

the Department for outpatient drugs and is eligible to enroll in the federal Drug Pricing Program under Section 340B of the federal Public Health Services Act shall enroll in that program. No entity participating in the federal Drug Pricing Program under Section 340B of the federal Public Health Services Act may exclude Medicaid from their participation in that program, although the Department may exclude entities defined in Section 1905(l)(2)(B) of the Social Security Act from this requirement.

(Source: P.A. 97-38, eff. 6-28-11; 97-74, eff. 6-30-11; 97-333, eff. 8-12-11; 97-426, eff. 1-1-12; 97-689, eff. 6-14-12; 97-813, eff. 7-13-12; 98-463, eff. 8-16-13.)

(305 ILCS 5/5-30)

Sec. 5-30. Care coordination.

(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including

primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

(b) Payment for such coordinated care shall be based on arrangements where the State pays for performance related to health care outcomes, the use of evidence-based practices, the use of primary care delivered through comprehensive medical homes, the use of electronic medical records, and the appropriate exchange of health information electronically made either on a capitated basis in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements.

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with

disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of the effective date of this amendatory Act of the 96th General Assembly.

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program report, beginning April, 2012 until April, 2016, on the progress and implementation of the care coordination program initiatives established by the provisions of this amendatory Act of the 96th General Assembly. The Department shall include in its April 2011 report a full analysis of federal laws or regulations regarding upper payment limitations to providers and the necessary revisions or adjustments in rate methodologies and payments to providers under this Code that would be necessary to implement coordinated care with full financial risk by a party other than the Department.

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

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

strategies.

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

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

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

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

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

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

the implementation to best facilitate the goals and objectives of this subsection (e).

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

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

(2) The hospital has not been offered a contract by a care coordination plan <u>that the Department has determined to be a good faith offer and</u> 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<u>, except to the</u>

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 MCO or other entity to pay claims within 30 days of receiving a bill that contains all the essential information needed to adjudicate the bill, and shall require the entity to pay a penalty that is at least equal to the penalty imposed under the Illinois Insurance~~

~~Code for any claims not paid within this time period~~ 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.

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

(305 ILCS 5/5-30.1 new)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

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

"Emergency services" include:

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

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

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

(4) emergency medical conditions, as defined by Section 10 of the Managed Care Reform and Patient Rights Act.

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

(c) An MCO shall pay any provider of emergency services that does not have in effect a contract with the contracted Medicaid MCO. The default rate of reimbursement shall be the

rate paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates.

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

(1) the MCO authorized such services;

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

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

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall

be made at the default rate of reimbursement paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

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

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

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

(3) The MCO shall have no obligation to cover medical services provided on an emergency basis that are not covered services under the contract.

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

(5) The determination of the attending emergency physician, or the provider actually treating the enrollee,

of whether an enrollee is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover emergency services for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider.

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

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

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

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

(D) the enrollee is discharged.

(f) Network adequacy.

(1) The Department shall:

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

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

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

(D) require MCOs to maintain an updated and public list of network providers.

(g) Timely payment of claims.

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

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

(3) The MCO shall pay a penalty that is at least equal to the penalty imposed under the Illinois Insurance Code for any claims not timely paid.

(4) The Department may establish a process for MCOs to expedite payments to providers based on criteria established by the Department.

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

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after the effective date of this amendatory Act of

the 98th General Assembly.

Article 10

Section 10-5. The Specialized Mental Health Rehabilitation Act of 2013 is amended by changing Sections 1-101.5, 1-101.6, 1-102, 4-108, and 5-101 and by adding Section 4-108.5 as follows:

(210 ILCS 49/1-101.5)

Sec. 1-101.5. Prior law.

(a) This Act provides for licensure of long term care facilities that are federally designated as institutions for the mentally diseased on the effective date of this Act and specialize in providing services to individuals with a serious mental illness. On and after the effective date of this Act, these facilities shall be governed by this Act instead of the Nursing Home Care Act.

(b) All consent decrees that apply to facilities federally designated as institutions for the mentally diseased shall continue to apply to facilities licensed under this Act.

(c) A facility licensed under this Act may voluntarily close, and the facility may reopen in an underserved region of the State, if the facility receives a certificate of need from the Health Facilities and Services Review Board. At no time shall the total number of licensed beds under this Act exceed

the total number of licensed beds existing on July 22, 2013 (the effective date of Public Act 98-104).

(Source: P.A. 98-104, eff. 7-22-13.)

(210 ILCS 49/1-101.6)

Sec. 1-101.6. Mental health system planning. The General Assembly finds the services contained in this Act are necessary for the effective delivery of mental health services for the citizens of the State of Illinois. The General Assembly also finds that the mental health system in the State requires further review to develop additional needed services. To ensure the adequacy of community-based services and to offer choice to all individuals with serious mental illness who choose to live in the community, and for whom the community is the appropriate setting, but are at risk of institutional care, the Governor shall convene a working group to develop the process and procedure for identifying needed services in the different geographic regions of the State. The Governor shall include the Division of Mental Health of the Department of Human Services, the Department of Healthcare and Family Services, the Department of Public Health, community mental health providers, statewide associations of mental health providers, mental health advocacy groups, and any other entity as deemed appropriate for participation in the working group. The Department of Human Services shall provide staff and support to this working group.

Before September 1, 2014, the State shall develop and implement a service authorization system available 24 hours a day, 7 days a week for approval of services in the following 3 levels of care under this Act: crisis stabilization; recovery and rehabilitation supports; and transitional living units.

(Source: P.A. 98-104, eff. 7-22-13.)

(210 ILCS 49/1-102)

Sec. 1-102. Definitions. For the purposes of this Act, unless the context otherwise requires:

"Abuse" means any physical or mental injury or sexual assault inflicted on a consumer other than by accidental means in a facility.

"Accreditation" means any of the following:

(1) the Joint Commission;

(2) the Commission on Accreditation of Rehabilitation Facilities;

(3) the Healthcare Facilities Accreditation Program; or

(4) any other national standards of care as approved by the Department.

"Applicant" means any person making application for a license or a provisional license under this Act.

"Consumer" means a person, 18 years of age or older, admitted to a mental health rehabilitation facility for evaluation, observation, diagnosis, treatment, stabilization,

recovery, and rehabilitation.

"Consumer" does not mean any of the following:

(i) an individual requiring a locked setting;

(ii) an individual requiring psychiatric hospitalization because of an acute psychiatric crisis;

(iii) an individual under 18 years of age;

(iv) an individual who is actively suicidal or violent toward others;

(v) an individual who has been found unfit to stand trial;

(vi) an individual who has been found not guilty by reason of insanity based on committing a violent act, such as sexual assault, assault with a deadly weapon, arson, or murder;

(vii) an individual subject to temporary detention and examination under Section 3-607 of the Mental Health and Developmental Disabilities Code;

(viii) an individual deemed clinically appropriate for inpatient admission in a State psychiatric hospital; and

(ix) an individual transferred by the Department of Corrections pursuant to Section 3-8-5 of the Unified Code of Corrections.

"Consumer record" means a record that organizes all information on the care, treatment, and rehabilitation services rendered to a consumer in a specialized mental health rehabilitation facility.

"Controlled drugs" means those drugs covered under the federal Comprehensive Drug Abuse Prevention Control Act of 1970, as amended, or the Illinois Controlled Substances Act.

"Department" means the Department of Public Health.

"Discharge" means the full release of any consumer from a facility.

"Drug administration" means the act in which a single dose of a prescribed drug or biological is given to a consumer. The complete act of administration entails removing an individual dose from a container, verifying the dose with the prescriber's orders, giving the individual dose to the consumer, and promptly recording the time and dose given.

"Drug dispensing" means the act entailing the following of a prescription order for a drug or biological and proper selection, measuring, packaging, labeling, and issuance of the drug or biological to a consumer.

"Emergency" means a situation, physical condition, or one or more practices, methods, or operations which present imminent danger of death or serious physical or mental harm to consumers of a facility.

"Facility" means a specialized mental health rehabilitation facility that provides at least one of the following services: (1) triage center; (2) crisis stabilization; (3) recovery and rehabilitation supports; or (4) transitional living units for 3 or more persons. The facility shall provide a 24-hour program that provides

intensive support and recovery services designed to assist persons, 18 years or older, with mental disorders to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. It includes facilities that meet the following criteria:

(1) 100% of the consumer population of the facility has a diagnosis of serious mental illness;

(2) no more than 15% of the consumer population of the facility is 65 years of age or older;

(3) none of the consumers are non-ambulatory;

(4) none of the consumers have a primary diagnosis of moderate, severe, or profound intellectual disability; and

(5) the facility must have been licensed under the Specialized Mental Health Rehabilitation Act or the Nursing Home Care Act immediately preceding the effective date of this Act and qualifies as a institute for mental disease under the federal definition of the term.

"Facility" does not include the following:

(1) a home, institution, or place operated by the federal government or agency thereof, or by the State of Illinois;

(2) a hospital, sanitarium, or other institution whose principal activity or business is the diagnosis, care, and treatment of human illness through the maintenance and operation as organized facilities therefor which is required to be licensed under the Hospital Licensing Act;

(3) a facility for child care as defined in the Child Care Act of 1969;

(4) a community living facility as defined in the Community Living Facilities Licensing Act;

(5) a nursing home or sanatorium operated solely by and for persons who rely exclusively upon treatment by spiritual means through prayer, in accordance with the creed or tenets of any well-recognized church or religious denomination; however, such nursing home or sanatorium shall comply with all local laws and rules relating to sanitation and safety;

(6) a facility licensed by the Department of Human Services as a community-integrated living arrangement as defined in the Community-Integrated Living Arrangements Licensure and Certification Act;

(7) a supportive residence licensed under the Supportive Residences Licensing Act;

(8) a supportive living facility in good standing with the program established under Section 5-5.01a of the Illinois Public Aid Code, except only for purposes of the employment of persons in accordance with Section 3-206.01 of the Nursing Home Care Act;

(9) an assisted living or shared housing establishment licensed under the Assisted Living and Shared Housing Act, except only for purposes of the employment of persons in accordance with Section 3-206.01 of the Nursing Home Care

Act;

(10) an Alzheimer's disease management center alternative health care model licensed under the Alternative Health Care Delivery Act;

(11) a home, institution, or other place operated by or under the authority of the Illinois Department of Veterans' Affairs;

(12) a facility licensed under the ID/DD Community Care Act; or

(13) a facility licensed under the Nursing Home Care Act after the effective date of this Act.

"Executive director" means a person who is charged with the general administration and supervision of a facility licensed under this Act.

"Guardian" means a person appointed as a guardian of the person or guardian of the estate, or both, of a consumer under the Probate Act of 1975.

"Identified offender" means a person who meets any of the following criteria:

(1) Has been convicted of, found guilty of, adjudicated delinquent for, found not guilty by reason of insanity for, or found unfit to stand trial for, any felony offense listed in Section 25 of the Health Care Worker Background Check Act, except for the following:

(i) a felony offense described in Section 10-5 of the Nurse Practice Act;

(ii) a felony offense described in Section 4, 5, 6, 8, or 17.02 of the Illinois Credit Card and Debit Card Act;

(iii) a felony offense described in Section 5, 5.1, 5.2, 7, or 9 of the Cannabis Control Act;

(iv) a felony offense described in Section 401, 401.1, 404, 405, 405.1, 407, or 407.1 of the Illinois Controlled Substances Act; and

(v) a felony offense described in the Methamphetamine Control and Community Protection Act.

(2) Has been convicted of, adjudicated delinquent for, found not guilty by reason of insanity for, or found unfit to stand trial for, any sex offense as defined in subsection (c) of Section 10 of the Sex Offender Management Board Act.

"Transitional living units" are residential units within a facility that have the purpose of assisting the consumer in developing and reinforcing the necessary skills to live independently outside of the facility. The duration of stay in such a setting shall not exceed 120 days for each consumer. Nothing in this definition shall be construed to be a prerequisite for transitioning out of a facility.

"Licensee" means the person, persons, firm, partnership, association, organization, company, corporation, or business trust to which a license has been issued.

"Misappropriation of a consumer's property" means the

deliberate misplacement, exploitation, or wrongful temporary or permanent use of a consumer's belongings or money without the consent of a consumer or his or her guardian.

"Neglect" means a facility's failure to provide, or willful withholding of, adequate medical care, mental health treatment, psychiatric rehabilitation, personal care, or assistance that is necessary to avoid physical harm and mental anguish of a consumer.

"Personal care" means assistance with meals, dressing, movement, bathing, or other personal needs, maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his or her person, whether or not a guardian has been appointed for such individual. "Personal care" shall not be construed to confine or otherwise constrain a facility's pursuit to develop the skills and abilities of a consumer to become self-sufficient and capable of increasing levels of independent functioning.

"Recovery and rehabilitation supports" means a program that facilitates a consumer's longer-term symptom management and stabilization while preparing the consumer for transitional living units by improving living skills and community socialization. The duration of stay in such a setting shall be established by the Department by rule.

"Restraint" means:

(i) a physical restraint that is any manual method or physical or mechanical device, material, or equipment attached or adjacent to a consumer's body that the consumer cannot remove easily and restricts freedom of movement or normal access to one's body; devices used for positioning, including, but not limited to, bed rails, gait belts, and cushions, shall not be considered to be restraints for purposes of this Section; or

(ii) a chemical restraint that is any drug used for discipline or convenience and not required to treat medical symptoms; the Department shall, by rule, designate certain devices as restraints, including at least all those devices that have been determined to be restraints by the United States Department of Health and Human Services in interpretive guidelines issued for the purposes of administering Titles XVIII and XIX of the federal Social Security Act. For the purposes of this Act, restraint shall be administered only after utilizing a coercive free environment and culture.

"Self-administration of medication" means consumers shall be responsible for the control, management, and use of their own medication.

"Crisis stabilization" means a secure and separate unit that provides short-term behavioral, emotional, or psychiatric crisis stabilization as an alternative to hospitalization or re-hospitalization for consumers from residential or community

placement. The duration of stay in such a setting shall not exceed 21 days for each consumer.

"Therapeutic separation" means the removal of a consumer from the milieu to a room or area which is designed to aid in the emotional or psychiatric stabilization of that consumer.

"Triage center" means a non-residential 23-hour center that serves as an alternative to emergency room care, hospitalization, or re-hospitalization for consumers in need of short-term crisis stabilization. Consumers may access a triage center from a number of referral sources, including family, emergency rooms, hospitals, community behavioral health providers, federally qualified health providers, or schools, including colleges or universities. A triage center may be located in a building separate from the licensed location of a facility, but shall not be more than 1,000 feet from the licensed location of the facility and must meet all of the facility standards applicable to the licensed location. If the triage center does operate in a separate building, safety personnel shall be provided, on site, 24 hours per day and the triage center shall meet all other staffing requirements without counting any staff employed in the main facility building.

(Source: P.A. 98-104, eff. 7-22-13.)

(210 ILCS 49/4-108)

Sec. 4-108. Surveys and inspections. The Department shall

conduct surveys of licensed facilities and their certified programs and services. The Department shall review the records or premises, or both, as it deems appropriate for the purpose of determining compliance with this Act and the rules promulgated under this Act. The Department shall have access to and may reproduce or photocopy any books, records, and other documents maintained by the facility to the extent necessary to carry out this Act and the rules promulgated under this Act. The Department shall not divulge or disclose the contents of a record under this Section as otherwise prohibited by this Act. Any holder of a license or applicant for a license shall be deemed to have given consent to any authorized officer, employee, or agent of the Department to enter and inspect the facility in accordance with this Article. Refusal to permit such entry or inspection shall constitute grounds for denial, suspension, or revocation of a license under this Act.

(1) The Department shall conduct surveys to determine compliance and may conduct surveys to investigate complaints.

(2) Determination of compliance with the service requirements shall be based on a survey centered on individuals that sample services being provided.

(3) Determination of compliance with the general administrative requirements shall be based on a review of facility records and observation of individuals and staff.

(4) The Department shall conduct surveys of licensed

facilities and their certified programs and services to determine the extent to which these facilities provide high quality interventions, especially evidence-based practices, appropriate to the assessed clinical needs of individuals in the various levels of care.

(Source: P.A. 98-104, eff. 7-22-13.)

(210 ILCS 49/4-108.5 new)

Sec. 4-108.5. Provisional licensure period; surveys. During the provisional licensure period, the Department shall conduct surveys to determine compliance with timetables and benchmarks with a facility's provisional licensure application plan of operation. Timetables and benchmarks shall be established in rule and shall include, but not be limited to, the following: (1) training of new and existing staff; (2) establishment of a data collection and reporting program for the facility's Quality Assessment and Performance Improvement Program; and (3) compliance with building environment standards beyond compliance with Chapter 33 of the National Fire Protection Association (NFPA) 101 Life Safety Code.

During the provisional licensure period, the Department shall conduct State licensure surveys as well as a conformance standard review to determine compliance with timetables and benchmarks associated with the accreditation process. Timetables and benchmarks shall be met in accordance with the preferred accrediting organization conformance standards and

recommendations and shall include, but not be limited to, conducting a comprehensive facility self-evaluation in accordance with an established national accreditation program. The facility shall submit all data reporting and outcomes required by accrediting organization to the Department of Public Health for review to determine progress towards accreditation. Accreditation status shall supplement but not replace the State's licensure surveys of facilities licensed under this Act and their certified programs and services to determine the extent to which these facilities provide high quality interventions, especially evidence-based practices, appropriate to the assessed clinical needs of individuals in the 4 certified levels of care.

Except for incidents involving the potential for harm, serious harm, death, or substantial facility failure to address a serious systemic issue within 60 days, findings of the facility's root cause analysis of problems and the facility's Quality Assessment and Performance Improvement program in accordance with item (22) of Section 4-104 shall not be used as a basis for non-compliance.

The Department shall have the authority to hire licensed practitioners of the healing arts and qualified mental health professionals to consult with and participate in survey and inspection activities.

(210 ILCS 49/5-101)

Sec. 5-101. Managed care entity, coordinated care entity, and accountable care entity payments. For facilities licensed by the Department of Public Health under this Act, the payment for services provided shall be determined by negotiation with managed care entities, coordinated care entities, or accountable care entities. However, for 3 years after the effective date of this Act, in no event shall the reimbursement rate paid to facilities licensed under this Act be less than the rate in effect on June 30, 2013 less $7.07 times the number of occupied bed days, as that term is defined in Article V-B of the Illinois Public Aid Code, for each facility previously licensed under the Nursing Home Care Act on June 30, 2013; or the rate in effect on June 30, 2013 for each facility licensed under the Specialized Mental Health Rehabilitation Act on June 30, 2013. Any adjustment in the support component or the capital component for facilities licensed by the Department of Public Health under the Nursing Home Care Act shall apply equally to facilities licensed by the Department of Public Health under this Act for the duration of the provisional licensure period as defined in Section 4-105 of this Act.

The Department of Healthcare and Family Services shall publish a reimbursement rate for triage, crisis stabilization, and transitional living services by December 1, 2014.

(Source: P.A. 98-104, eff. 7-22-13.)

Article 15

Section 15-5. The Illinois Public Aid Code is amended by changing Sections 5A-8 and 5A-12.2 as follows:

(305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

Sec. 5A-8. Hospital Provider Fund.

(a) There is created in the State Treasury the Hospital Provider Fund. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any moneys appropriated to the Medicaid program by the General Assembly.

(b) The Fund is created for the purpose of receiving moneys in accordance with Section 5A-6 and disbursing moneys only for the following purposes, notwithstanding any other provision of law:

(1) For making payments to hospitals as required under this Code, under the Children's Health Insurance Program Act, under the Covering ALL KIDS Health Insurance Act, and under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act.

(2) For the reimbursement of moneys collected by the Illinois Department from hospitals or hospital providers through error or mistake in performing the activities authorized under this Code.

(3) For payment of administrative expenses incurred by the Illinois Department or its agent in performing activities under this Code, under the Children's Health

Insurance Program Act, under the Covering ALL KIDS Health Insurance Act, and under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act.

(4) For payments of any amounts which are reimbursable to the federal government for payments from this Fund which are required to be paid by State warrant.

(5) For making transfers, as those transfers are authorized in the proceedings authorizing debt under the Short Term Borrowing Act, but transfers made under this paragraph (5) shall not exceed the principal amount of debt issued in anticipation of the receipt by the State of moneys to be deposited into the Fund.

(6) For making transfers to any other fund in the State treasury, but transfers made under this paragraph (6) shall not exceed the amount transferred previously from that other fund into the Hospital Provider Fund plus any interest that would have been earned by that fund on the monies that had been transferred.

(6.5) For making transfers to the Healthcare Provider Relief Fund, except that transfers made under this paragraph (6.5) shall not exceed $60,000,000 in the aggregate.

(7) For making transfers not exceeding the following amounts, related to ~~in~~ State fiscal years 2013 through 2018 ~~and 2014~~, to the following designated funds:

Health and Human Services Medicaid Trust

Fund $20,000,000

Long-Term Care Provider Fund $30,000,000

General Revenue Fund ..... $80,000,000.

Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.

(7.1) (Blank). ~~For making transfers not exceeding the following amounts, in State fiscal year 2015, to the following designated funds:~~

~~Health and Human Services Medicaid Trust Fund..... $10,000,000~~

~~Long-Term Care Provider Fund ..... $15,000,000~~

~~General Revenue Fund ..... $40,000,000.~~

~~Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.~~

(7.5) (Blank).

(7.8) (Blank).

(7.9) (Blank).

(7.10) For State fiscal year ~~years 2013 and~~ 2014, for making transfers of the moneys resulting from the assessment under subsection (b-5) of Section 5A-2 and received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section

5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Health Care Provider Relief Fund .... $100,000,000 ~~$50,000,000~~

Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.

The additional amount of transfers in this paragraph (7.10), authorized by this amendatory Act of the 98th General Assembly, shall be made within 10 State business days after the effective date of this amendatory Act of the 98th General Assembly. That authority shall remain in effect even if this amendatory Act of the 98th General Assembly does not become law until State fiscal year 2015.

(7.10a) For State fiscal years 2015 through 2018, for making transfers of the moneys resulting from the assessment under subsection (b-5) of Section 5A-2 and received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts related to each State fiscal year:

Health Care Provider Relief Fund $50,000,000

Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the

schedule of payments provided in subsection (a) of Section 5A-4.

(7.11) (Blank). ~~For State fiscal year 2015, for making transfers of the moneys resulting from the assessment under subsection (b-5) of Section 5A-2 and received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:~~

~~Health Care Provider Relief Fund .... $25,000,000~~

~~Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.~~

(7.12) For State fiscal year 2013, for increasing by 21/365ths the transfer of the moneys resulting from the assessment under subsection (b-5) of Section 5A-2 and received from hospital providers under Section 5A-4 for the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:

Health Care Provider Relief Fund $2,870,000

Since the federal Centers for Medicare and Medicaid Services approval of the assessment authorized under

subsection (b-5) of Section 5A-2, received from hospital providers under Section 5A-4 and the payment methodologies to hospitals required under Section 5A-12.4 was not received by the Department until State fiscal year 2014 and since the Department made retroactive payments during State fiscal year 2014 related to the referenced period of June 2012, the transfer authority granted in this paragraph (7.12) is extended through the date that is 10 State business days after the effective date of this amendatory Act of the 98th General Assembly.

(8) For making refunds to hospital providers pursuant to Section 5A-10.

(9) For making payment to capitated managed care organizations as described in subsections (s) and (t) of Section 5A-12.2 of this Code.

Disbursements from the Fund, other than transfers authorized under paragraphs (5) and (6) of this subsection, shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois Department.

(c) The Fund shall consist of the following:

(1) All moneys collected or received by the Illinois Department from the hospital provider assessment imposed by this Article.

(2) All federal matching funds received by the Illinois Department as a result of expenditures made by the Illinois

Department that are attributable to moneys deposited in the Fund.

(3) Any interest or penalty levied in conjunction with the administration of this Article.

(3.5) As applicable, proceeds from surety bond payments payable to the Department as referenced in subsection (s) of Section 5A-12.2 of this Code.

(4) Moneys transferred from another fund in the State treasury.

(5) All other moneys received for the Fund from any other source, including interest earned thereon.

(d) (Blank).

(Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12; 98-104, eff. 7-22-13; 98-463, eff. 8-16-13; revised 10-21-13.)

(305 ILCS 5/5A-12.2)

(Section scheduled to be repealed on January 1, 2015)

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

(a) To preserve and improve access to hospital services, for hospital services rendered on or after July 1, 2008, the Illinois Department shall, except for hospitals described in subsection (b) of Section 5A-3, make payments to hospitals as set forth in this Section. These payments shall be paid in 12 equal installments on or before the seventh State business day of each month, except that no payment shall be due within 100

days after the later of the date of notification of federal approval of the payment methodologies required under this Section or any waiver required under 42 CFR 433.68, at which time the sum of amounts required under this Section prior to the date of notification is due and payable. Payments under this Section are not due and payable, however, until (i) the methodologies described in this Section are approved by the federal government in an appropriate State Plan amendment and (ii) the assessment imposed under this Article is determined to be a permissible tax under Title XIX of the Social Security Act.

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

(b) Across-the-board inpatient adjustment.

(1) In addition to rates paid for inpatient hospital services, the Department shall pay to each Illinois general acute care hospital an amount equal to 40% of the total base inpatient payments paid to the hospital for services provided in State fiscal year 2005.

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

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

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

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

(i) For freestanding children's hospitals as defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5

multiplied by the hospital's pediatric inpatient adjustment payment required under 89 Ill. Adm. Code 148.298, as in effect for State fiscal year 2008.

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

(c) Outpatient adjustment.

(1) In addition to the rates paid for outpatient hospital services, the Department shall pay each Illinois hospital an amount equal to 2.2 multiplied by the hospital's ambulatory procedure listing payments for categories 1, 2, 3, and 4, as defined in 89 Ill. Adm. Code 148.140(b), for State fiscal year 2005.

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

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

year 2005 amounts as follows:

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

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

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

(1) For each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 10% and less than 36.94% and whose capital cost is less than the 60th percentile of the capital costs of all Illinois hospitals, the amount of such payment shall equal the hospital's Medicaid inpatient days multiplied by the difference between the capital costs at the 60th percentile of the capital costs of all Illinois hospitals and the hospital's capital costs.

(2) For each Illinois general acute care hospital that has a Medicaid inpatient utilization rate of at least 36.94% and whose capital cost is less than the 75th

percentile of the capital costs of all Illinois hospitals, the amount of such payment shall equal the hospital's Medicaid inpatient days multiplied by the difference between the capital costs at the 75th percentile of the capital costs of all Illinois hospitals and the hospital's capital costs.

(f) Obstetrical care adjustment.

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

(2) In addition to rates paid for inpatient hospital services, the Department shall pay $1,350 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois general acute care hospital that was designated a level III perinatal center as of December 31, 2006, and that had a case mix index equal to or greater than the 45th percentile of the case mix indices for all level III perinatal centers.

(3) In addition to rates paid for inpatient hospital services, the Department shall pay $900 for each Medicaid obstetrical day of care provided in State fiscal year 2005 by each Illinois general acute care hospital that was

designated a level II or II+ perinatal center as of December 31, 2006, and that had a case mix index equal to or greater than the 35th percentile of the case mix indices for all level II and II+ perinatal centers.

(g) Trauma adjustment.

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

(2) In addition to rates paid for inpatient hospital services, the Department shall pay $400 for each Medicaid acute inpatient day of care provided in State fiscal year 2005 by each Illinois general acute care hospital that was designated a level II trauma center, as defined in 89 Ill. Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1, 2007.

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

(h) Supplemental tertiary care adjustment. In addition to rates paid for inpatient services, the Department shall pay to

each Illinois hospital eligible for tertiary care adjustment payments under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2007, a supplemental tertiary care adjustment payment equal to the tertiary care adjustment payment required under 89 Ill. Adm. Code 148.296, as in effect for State fiscal year 2007.

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

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

(1) For hospitals located in a county whose eligibility growth factor is greater than the mean, $450 multiplied by the eligibility growth factor for the county in which the

hospital is located for each Medicaid inpatient day of care provided by the hospital during State fiscal year 2005.

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

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

(k) For purposes of this Section, a hospital that is enrolled to provide Medicaid services during State fiscal year 2005 shall have its utilization and associated reimbursements annualized prior to the payment calculations being performed under this Section.

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

(m) For purposes of this Section, in determining the percentile ranking of an Illinois hospital's case mix index or

capital costs, hospitals described in subsection (b) of Section 5A-3 shall be excluded from the ranking.

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

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

"Base inpatient payments" means, for a given hospital, the sum of base payments for inpatient services made on a per diem or per admission (DRG) basis, excluding those portions of per admission payments that are classified as capital payments. Disproportionate share hospital adjustment payments, Medicaid Percentage Adjustments, Medicaid High Volume Adjustments, and outlier payments, as defined by rule by the Department as of January 1, 2008, are not base payments.

"Capital costs" means, for a given hospital, the total capital costs determined using the most recent 2005 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on December 31, 2006, divided by the total inpatient days from the same cost report to calculate a capital cost per day. The resulting capital cost per day is inflated to the midpoint of State

fiscal year 2009 utilizing the national hospital market price proxies (DRI) hospital cost index. If a hospital's 2005 Medicare cost report is not contained in the Healthcare Cost Report Information System, the Department may obtain the data necessary to compute the hospital's capital costs from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Illinois Department or its duly authorized agents and employees.

"Case mix index" means, for a given hospital, the sum of the DRG relative weighting factors in effect on January 1, 2005, for all general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82, divided by the total number of general acute care admissions for State fiscal year 2005, excluding Medicare crossover admissions and transplant admissions reimbursed under 89 Ill. Adm. Code 148.82.

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

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

"Outpatient ambulatory procedure listing payments" means, for a given hospital, the sum of payments for ambulatory procedure listing services, as described in 89 Ill. Adm. Code 148.140(b), provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding payments for individuals eligible for Medicare under Title XVIII of the Act (Medicaid/Medicare crossover days), as tabulated from the Department's paid claims data for services occurring in State fiscal year 2005 that were adjudicated by the Department through March 23, 2007.

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

(p) Notwithstanding any of the other provisions of this Section, the Department is authorized to adopt rules that change the hospital access improvement payments specified in

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

(q) (Blank).

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

(s) On or after July 1, 2014, but no later than October 1, 2014, and no less than annually thereafter, the Department may increase capitation payments to capitated managed care organizations (MCOs) to equal the aggregate reduction of payments made in this Section and in Section 5A-12.4 by a uniform percentage on a regional basis to preserve access to hospital services for recipients under the Illinois Medical Assistance Program. The aggregate amount of all increased capitation payments to all MCOs for a fiscal year shall be the amount needed to avoid reduction in payments authorized under Section 5A-15. Payments to MCOs under this Section shall be consistent with actuarial certification and shall be published

by the Department each year. Each MCO shall only expend the increased capitation payments it receives under this Section to support the availability of hospital services and to ensure access to hospital services, with such expenditures being made within 15 calendar days from when the MCO receives the increased capitation payment. The Department shall make available, on a monthly basis, a report of the capitation payments that are made to each MCO pursuant to this subsection, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. Payments made under this subsection shall be guaranteed by a surety bond obtained by the MCO in an amount established by the Department to approximate one month's liability of payments authorized under this subsection. The Department may advance the payments guaranteed by the surety bond. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this Section shall not be reduced as a consequence of payments made under this subsection.

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

(t) On or after July 1, 2014, the Department may increase capitation payments to capitated managed care organizations (MCOs) to equal the aggregate reduction of payments made in

Section 5A-12.5 to preserve access to hospital services for recipients under the Illinois Medical Assistance Program. Payments to MCOs under this Section shall be consistent with actuarial certification and shall be published by the Department each year. Each MCO shall only expend the increased capitation payments it receives under this Section to support the availability of hospital services and to ensure access to hospital services, with such expenditures being made within 15 calendar days from when the MCO receives the increased capitation payment. The Department may advance the payments to hospitals under this subsection, in the event the MCO fails to make such payments. The Department shall make available, on a monthly basis, a report of the capitation payments that are made to each MCO pursuant to this subsection, including the number of enrollees for which such payment is made, the per enrollee amount of the payment, and any adjustments that have been made. Payments to MCOs that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this subsection shall not be reduced as a consequence of payments made under this subsection.

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

(Source: P.A. 96-821, eff. 11-20-09; 97-689, eff. 6-14-12.)

Article 20

Section 20-5. The Illinois Administrative Procedure Act is amended by changing Section 5-45 as follows:

(5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

Sec. 5-45. Emergency rulemaking.

(a) "Emergency" means the existence of any situation that any agency finds reasonably constitutes a threat to the public interest, safety, or welfare.

(b) If any agency finds that an emergency exists that requires adoption of a rule upon fewer days than is required by Section 5-40 and states in writing its reasons for that finding, the agency may adopt an emergency rule without prior notice or hearing upon filing a notice of emergency rulemaking with the Secretary of State under Section 5-70. The notice shall include the text of the emergency rule and shall be published in the Illinois Register. Consent orders or other court orders adopting settlements negotiated by an agency may be adopted under this Section. Subject to applicable constitutional or statutory provisions, an emergency rule becomes effective immediately upon filing under Section 5-65 or at a stated date less than 10 days thereafter. The agency's finding and a statement of the specific reasons for the finding shall be filed with the rule. The agency shall take reasonable and appropriate measures to make emergency rules known to the

persons who may be affected by them.

(c) An emergency rule may be effective for a period of not longer than 150 days, but the agency's authority to adopt an identical rule under Section 5-40 is not precluded. No emergency rule may be adopted more than once in any 24 month period, except that this limitation on the number of emergency rules that may be adopted in a 24 month period does not apply to (i) emergency rules that make additions to and deletions from the Drug Manual under Section 5-5.16 of the Illinois Public Aid Code or the generic drug formulary under Section 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii) emergency rules adopted by the Pollution Control Board before July 1, 1997 to implement portions of the Livestock Management Facilities Act, (iii) emergency rules adopted by the Illinois Department of Public Health under subsections (a) through (i) of Section 2 of the Department of Public Health Act when necessary to protect the public's health, (iv) emergency rules adopted pursuant to subsection (n) of this Section, (v) emergency rules adopted pursuant to subsection (o) of this Section, or (vi) emergency rules adopted pursuant to subsection (c-5) of this Section. Two or more emergency rules having substantially the same purpose and effect shall be deemed to be a single rule for purposes of this Section.

(c-5) To facilitate the maintenance of the program of group health benefits provided to annuitants, survivors, and retired employees under the State Employees Group Insurance Act of

1971, rules to alter the contributions to be paid by the State, annuitants, survivors, retired employees, or any combination of those entities, for that program of group health benefits, shall be adopted as emergency rules. The adoption of those rules shall be considered an emergency and necessary for the public interest, safety, and welfare.

(d) In order to provide for the expeditious and timely implementation of the State's fiscal year 1999 budget, emergency rules to implement any provision of Public Act 90-587 or 90-588 or any other budget initiative for fiscal year 1999 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (d). The adoption of emergency rules authorized by this subsection (d) shall be deemed to be necessary for the public interest, safety, and welfare.

(e) In order to provide for the expeditious and timely implementation of the State's fiscal year 2000 budget, emergency rules to implement any provision of this amendatory Act of the 91st General Assembly or any other budget initiative for fiscal year 2000 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections

5-115 and 5-125 do not apply to rules adopted under this subsection (e). The adoption of emergency rules authorized by this subsection (e) shall be deemed to be necessary for the public interest, safety, and welfare.

(f) In order to provide for the expeditious and timely implementation of the State's fiscal year 2001 budget, emergency rules to implement any provision of this amendatory Act of the 91st General Assembly or any other budget initiative for fiscal year 2001 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (f). The adoption of emergency rules authorized by this subsection (f) shall be deemed to be necessary for the public interest, safety, and welfare.

(g) In order to provide for the expeditious and timely implementation of the State's fiscal year 2002 budget, emergency rules to implement any provision of this amendatory Act of the 92nd General Assembly or any other budget initiative for fiscal year 2002 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (g). The adoption of emergency rules authorized by

this subsection (g) shall be deemed to be necessary for the public interest, safety, and welfare.

(h) In order to provide for the expeditious and timely implementation of the State's fiscal year 2003 budget, emergency rules to implement any provision of this amendatory Act of the 92nd General Assembly or any other budget initiative for fiscal year 2003 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (h). The adoption of emergency rules authorized by this subsection (h) shall be deemed to be necessary for the public interest, safety, and welfare.

(i) In order to provide for the expeditious and timely implementation of the State's fiscal year 2004 budget, emergency rules to implement any provision of this amendatory Act of the 93rd General Assembly or any other budget initiative for fiscal year 2004 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (i). The adoption of emergency rules authorized by this subsection (i) shall be deemed to be necessary for the public interest, safety, and welfare.

(j) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2005 budget as provided under the Fiscal Year 2005 Budget Implementation (Human Services) Act, emergency rules to implement any provision of the Fiscal Year 2005 Budget Implementation (Human Services) Act may be adopted in accordance with this Section by the agency charged with administering that provision, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (j). The Department of Public Aid may also adopt rules under this subsection (j) necessary to administer the Illinois Public Aid Code and the Children's Health Insurance Program Act. The adoption of emergency rules authorized by this subsection (j) shall be deemed to be necessary for the public interest, safety, and welfare.

(k) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2006 budget, emergency rules to implement any provision of this amendatory Act of the 94th General Assembly or any other budget initiative for fiscal year 2006 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative, except that the 24-month limitation on the adoption of emergency rules and the provisions of Sections 5-115 and 5-125 do not apply to rules adopted under this subsection (k). The Department of Healthcare and Family

Services may also adopt rules under this subsection (k) necessary to administer the Illinois Public Aid Code, the Senior Citizens and Disabled Persons Property Tax Relief Act, the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act (now the Illinois Prescription Drug Discount Program Act), and the Children's Health Insurance Program Act. The adoption of emergency rules authorized by this subsection (k) shall be deemed to be necessary for the public interest, safety, and welfare.

(l) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2007 budget, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2007, including rules effective July 1, 2007, in accordance with this subsection to the extent necessary to administer the Department's responsibilities with respect to amendments to the State plans and Illinois waivers approved by the federal Centers for Medicare and Medicaid Services necessitated by the requirements of Title XIX and Title XXI of the federal Social Security Act. The adoption of emergency rules authorized by this subsection (l) shall be deemed to be necessary for the public interest, safety, and welfare.

(m) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2008 budget, the Department of Healthcare and Family Services may adopt emergency rules during fiscal year 2008, including

rules effective July 1, 2008, in accordance with this subsection to the extent necessary to administer the Department's responsibilities with respect to amendments to the State plans and Illinois waivers approved by the federal Centers for Medicare and Medicaid Services necessitated by the requirements of Title XIX and Title XXI of the federal Social Security Act. The adoption of emergency rules authorized by this subsection (m) shall be deemed to be necessary for the public interest, safety, and welfare.

(n) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2010 budget, emergency rules to implement any provision of this amendatory Act of the 96th General Assembly or any other budget initiative authorized by the 96th General Assembly for fiscal year 2010 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative. The adoption of emergency rules authorized by this subsection (n) shall be deemed to be necessary for the public interest, safety, and welfare. The rulemaking authority granted in this subsection (n) shall apply only to rules promulgated during Fiscal Year 2010.

(o) In order to provide for the expeditious and timely implementation of the provisions of the State's fiscal year 2011 budget, emergency rules to implement any provision of this amendatory Act of the 96th General Assembly or any other budget initiative authorized by the 96th General Assembly for fiscal

year 2011 may be adopted in accordance with this Section by the agency charged with administering that provision or initiative. The adoption of emergency rules authorized by this subsection (o) is deemed to be necessary for the public interest, safety, and welfare. The rulemaking authority granted in this subsection (o) applies only to rules promulgated on or after the effective date of this amendatory Act of the 96th General Assembly through June 30, 2011.

(p) In order to provide for the expeditious and timely implementation of the provisions of Public Act 97-689, emergency rules to implement any provision of Public Act 97-689 may be adopted in accordance with this subsection (p) by the agency charged with administering that provision or initiative. The 150-day limitation of the effective period of emergency rules does not apply to rules adopted under this subsection (p), and the effective period may continue through June 30, 2013. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (p). The adoption of emergency rules authorized by this subsection (p) is deemed to be necessary for the public interest, safety, and welfare.

(q) In order to provide for the expeditious and timely implementation of the provisions of Articles 7, 8, 9, 11, and 12 of this amendatory Act of the 98th General Assembly, emergency rules to implement any provision of Articles 7, 8, 9, 11, and 12 of this amendatory Act of the 98th General Assembly

may be adopted in accordance with this subsection (q) by the agency charged with administering that provision or initiative. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (q). The adoption of emergency rules authorized by this subsection (q) is deemed to be necessary for the public interest, safety, and welfare.

(r) In order to provide for the expeditious and timely implementation of the provisions of this amendatory Act of the 98th General Assembly, emergency rules to implement this amendatory Act of the 98th General Assembly may be adopted in accordance with this subsection (r) by the Department of Healthcare and Family Services. The 24-month limitation on the adoption of emergency rules does not apply to rules adopted under this subsection (r). The adoption of emergency rules authorized by this subsection (r) is deemed to be necessary for the public interest, safety, and welfare.

(Source: P.A. 97-689, eff. 6-14-12; 97-695, eff. 7-1-12; 98-104, eff. 7-22-13; 98-463, eff. 8-16-13.)

Section 20-10. The Children's Health Insurance Program Act is amended by changing Section 7 as follows:

(215 ILCS 106/7)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for

benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

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

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

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data

obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to the recipient at least 60 days prior to the end of the period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

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

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically

verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

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

(Source: P.A. 96-1501, eff. 1-25-11.)

Section 20-15. The Covering ALL KIDS Health Insurance Act is amended by changing Sections 7 and 20 as follows:

(215 ILCS 170/7)

(Section scheduled to be repealed on July 1, 2016)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as

practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

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

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

(2) By October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the

requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

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

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program.

Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

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

(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/20)

(Section scheduled to be repealed on July 1, 2016)

Sec. 20. Eligibility.

(a) To be eligible for the Program, a person must be a child:

(1) who is a resident of the State of Illinois;

(2) who is ineligible for medical assistance under the Illinois Public Aid Code or benefits under the Children's Health Insurance Program Act;

(3) who ~~either~~ (i) effective July 1, 2014, ~~who has~~ in accordance with 42 CFR 457.805 (78 FR 42313, July 15, 2013) or any other federal requirement necessary to obtain federal financial participation for expenditures made under this Act, has been without health insurance coverage for 90 days; ~~12 months, (ii) whose parent has lost~~

~~employment that made available affordable dependent health insurance coverage, until such time as affordable employer-sponsored dependent health insurance coverage is again available for the child as set forth by the Department in rules, (iii)~~ (ii) ~~who~~ is a newborn whose responsible relative does not have available affordable private or employer-sponsored health insurance; or (iii) ~~, or (iv) who,~~ within one year of applying for coverage under this Act, lost medical benefits under the Illinois Public Aid Code or the Children's Health Insurance Program Act; and

(3.5) whose household income, as determined, effective October 1, 2013, by the Department, is at or below 300% of the federal poverty level as determined in compliance with 42 U.S.C. 1397bb(b)(1)(B)(v) and applicable federal regulations. ~~This item (3.5) is effective July 1, 2011.~~

An entity that provides health insurance coverage (as defined in Section 2 of the Comprehensive Health Insurance Plan Act) to Illinois residents shall provide health insurance data match to the Department of Healthcare and Family Services as provided by and subject to Section 5.5 of the Illinois Insurance Code. The Department of Healthcare and Family Services may impose an administrative penalty as provided under Section 12-4.45 of the Illinois Public Aid Code on entities that have established a pattern of failure to provide the information required under this Section.

The Department of Healthcare and Family Services, in collaboration with the Department of Insurance, shall adopt rules governing the exchange of information under this Section. The rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records, including provisions under the Federal Health Insurance Portability and Accountability Act (HIPAA).

(b) The Department shall monitor the availability and retention of employer-sponsored dependent health insurance coverage and shall modify the period described in subdivision (a)(3) if necessary to promote retention of private or employer-sponsored health insurance and timely access to healthcare services, but at no time shall the period described in subdivision (a)(3) be less than 6 months.

(c) The Department, at its discretion, may take into account the affordability of dependent health insurance when determining whether employer-sponsored dependent health insurance coverage is available upon reemployment of a child's parent as provided in subdivision (a)(3).

(d) A child who is determined to be eligible for the Program shall remain eligible for 12 months, provided that the child maintains his or her residence in this State, has not yet attained 19 years of age, and is not excluded under subsection (e).

(e) A child is not eligible for coverage under the Program if:

(1) the premium required under Section 40 has not been timely paid; if the required premiums are not paid, the liability of the Program shall be limited to benefits incurred under the Program for the time period for which premiums have been paid; re-enrollment shall be completed before the next covered medical visit, and the first month's required premium shall be paid in advance of the next covered medical visit; or

(2) the child is an inmate of a public institution or an institution for mental diseases.

(f) The Department may adopt rules, including, but not limited to: rules regarding annual renewals of eligibility for the Program in conformance with Section 7 of this Act; rules providing for re-enrollment, grace periods, notice requirements, and hearing procedures under subdivision (e)(1) of this Section; and rules regarding what constitutes availability and affordability of private or employer-sponsored health insurance, with consideration of such factors as the percentage of income needed to purchase children or family health insurance, the availability of employer subsidies, and other relevant factors.

(g) Each child enrolled in the Program as of July 1, 2011 whose family income, as established by the Department, exceeds 300% of the federal poverty level may remain enrolled in the Program for 12 additional months commencing July 1, 2011. Continued enrollment pursuant to this subsection shall be

available only if the child continues to meet all eligibility criteria established under the Program as of the effective date of this amendatory Act of the 96th General Assembly without a break in coverage. Nothing contained in this subsection shall prevent a child from qualifying for any other health benefits program operated by the Department.

(Source: P.A. 98-130, eff. 8-2-13.)

Section 20-20. The Illinois Public Aid Code is amended by changing Sections 5-2.1a and 11-5.1 as follows:

(305 ILCS 5/5-2.1a)

Sec. 5-2.1a. Treatment of trust amounts. To the extent required by federal law, the Department of Healthcare and Family Services ~~Illinois Department~~ shall provide by rule for the consideration of trusts and similar legal instruments or devices established by a person in the Illinois Department's determination of the person's eligibility for and the amount of assistance provided under this Article. ~~This Section shall be enforced by the Department of Human Services, acting as successor to the Department of Public Aid under the Department of Human Services Act.~~

(Source: P.A. 88-554, eff. 7-26-94; 89-507, eff. 7-1-97.)

(305 ILCS 5/11-5.1)

Sec. 11-5.1. Eligibility verification. Notwithstanding any

other provision of this Code, with respect to applications for medical assistance provided under Article V of this Code, eligibility shall be determined in a manner that ensures program integrity and complies with federal laws and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

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

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

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and

expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

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

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment

Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data shall be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

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

(Source: P.A. 96-1501, eff. 1-25-11.)

Article 25

Section 25-5. The State Finance Act is amended by changing Section 6z-30 as follows:

(30 ILCS 105/6z-30)

Sec. 6z-30. University of Illinois Hospital Services Fund.

(a) The University of Illinois Hospital Services Fund is

created as a special fund in the State Treasury. The following moneys shall be deposited into the Fund:

(1) As soon as possible after the beginning of fiscal year 2010, and in no event later than July 30, the State Comptroller and the State Treasurer shall automatically transfer $30,000,000 from the General Revenue Fund to the University of Illinois Hospital Services Fund.

(1.5) Starting in fiscal year 2011, as soon as possible after the beginning of each fiscal year, and in no event later than July 30, the State Comptroller and the State Treasurer shall automatically transfer $45,000,000 from the General Revenue Fund to the University of Illinois Hospital Services Fund; except that, in fiscal year 2012 only, the State Comptroller and the State Treasurer shall transfer $90,000,000 from the General Revenue Fund to the University of Illinois Hospital Services Fund under this paragraph, and, in fiscal year 2013 only, the State Comptroller and the State Treasurer shall transfer no amounts from the General Revenue Fund to the University of Illinois Hospital Services Fund under this paragraph.

(2) All intergovernmental transfer payments to the Department of Healthcare and Family Services by the University of Illinois made pursuant to an intergovernmental agreement under subsection (b) or (c) of Section 5A-3 of the Illinois Public Aid Code.

(3) All federal matching funds received by the

Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) as a result of expenditures made by the Department that are attributable to moneys that were deposited in the Fund.

(4) All other moneys received for the Fund from any other source, including interest earned thereon.

(b) Moneys in the fund may be used by the Department of Healthcare and Family Services, subject to appropriation and to an interagency agreement between that Department and the Board of Trustees of the University of Illinois, to reimburse the University of Illinois Hospital for hospital and pharmacy services, to reimburse practitioners who are employed by the University of Illinois, to reimburse other health care facilities and health plans operated by the University of Illinois, and to pass through to the University of Illinois federal financial participation earned by the State as a result of expenditures made by the University of Illinois.

(c) (Blank).

(Source: P.A. 96-45, eff. 7-15-09; 96-959, eff. 7-1-10; 97-732, eff. 6-30-12.)

Section 25-10. The Illinois Public Aid Code is amended by changing Section 12-9 as follows:

(305 ILCS 5/12-9) (from Ch. 23, par. 12-9)

Sec. 12-9. Public Aid Recoveries Trust Fund; uses. The

Public Aid Recoveries Trust Fund shall consist of (1) recoveries by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) authorized by this Code in respect to applicants or recipients under Articles III, IV, V, and VI, including recoveries made by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) from the estates of deceased recipients, (2) recoveries made by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) in respect to applicants and recipients under the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (2.5) recoveries made by the Department of Healthcare and Family Services in connection with the imposition of an administrative penalty as provided under Section 12-4.45, (3) federal funds received on behalf of and earned by State universities and local governmental entities for services provided to applicants or recipients covered under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (3.5) federal financial participation revenue related to eligible disbursements made by the Department of Healthcare and Family Services from appropriations required by this Section, and (4) all other moneys received to the Fund, including interest thereon. The Fund shall be held as a special fund in the State Treasury.

Disbursements from this Fund shall be only (1) for the reimbursement of claims collected by the Department of

Healthcare and Family Services (formerly Illinois Department of Public Aid) through error or mistake, (2) for payment to persons or agencies designated as payees or co-payees on any instrument, whether or not negotiable, delivered to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) as a recovery under this Section, such payment to be in proportion to the respective interests of the payees in the amount so collected, (3) for payments to the Department of Human Services for collections made by the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid) on behalf of the Department of Human Services under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (4) for payment of administrative expenses incurred in performing the activities authorized under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (5) for payment of fees to persons or agencies in the performance of activities pursuant to the collection of monies owed the State that are collected under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act, (6) for payments of any amounts which are reimbursable to the federal government which are required to be paid by State warrant by either the State or federal government, and (7) for payments to State universities and local governmental entities of federal funds for services provided to applicants or

recipients covered under this Code, the Children's Health Insurance Program Act, and the Covering ALL KIDS Health Insurance Act. Disbursements from this Fund for purposes of items (4) and (5) of this paragraph shall be subject to appropriations from the Fund to the Department of Healthcare and Family Services (formerly Illinois Department of Public Aid).

The balance in this Fund ~~on the first day of each calendar quarter,~~ after payment therefrom of any amounts reimbursable to the federal government, and minus the amount reasonably anticipated to be needed to make the disbursements ~~during that quarter~~ authorized by this Section during the current and following 3 calendar months, shall be certified by the Director of Healthcare and Family Services and transferred by the State Comptroller to the Drug Rebate Fund or the Healthcare Provider Relief Fund in the State Treasury, as appropriate, on at least an annual basis by June 30th of each fiscal year ~~within 30 days of the first day of each calendar quarter~~. The Director of Healthcare and Family Services may certify and the State Comptroller shall transfer to the Drug Rebate Fund or the Healthcare Provider Relief Fund amounts on a more frequent basis.

On July 1, 1999, the State Comptroller shall transfer the sum of $5,000,000 from the Public Aid Recoveries Trust Fund (formerly the Public Assistance Recoveries Trust Fund) into the DHS Recoveries Trust Fund.

(Source: P.A. 97-647, eff. 1-1-12; 97-689, eff. 6-14-12; 98-130, eff. 8-2-13.)

Article 30

Section 30-5. The Illinois Public Aid Code is amended by adding Section 5A-12.5 as follows:

(305 ILCS 5/5A-12.5 new)

Sec. 5A-12.5. Affordable Care Act adults; hospital access payments. The Department shall, subject to federal approval, mirror the Medical Assistance hospital reimbursement methodology, including hospital access payments as defined in Section 5A-12.2 of this Article and hospital access improvement payments as defined in Section 5A-12.4 of this Article, in compliance with the equivalent rate provisions of the Affordable Care Act.

As used in this Section, "Affordable Care Act" is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Article 35

Section 35-5. The Hospital Licensing Act is amended by changing Section 6.09 as follows:

(210 ILCS 85/6.09) (from Ch. 111 1/2, par. 147.09)

Sec. 6.09. (a) In order to facilitate the orderly transition of aged and disabled patients from hospitals to post-hospital care, whenever a patient who qualifies for the federal Medicare program is hospitalized, the patient shall be notified of discharge at least 24 hours prior to discharge from the hospital. With regard to pending discharges to a skilled nursing facility, the hospital must notify the case coordination unit, as defined in 89 Ill. Adm. Code 240.260, at least 24 hours prior to discharge. When the assessment is completed in the hospital, the case coordination unit shall provide the discharge planner with a copy of the prescreening information and accompanying materials, which the discharge planner shall transmit when the patient is discharged to a skilled nursing facility. If ~~or, if~~ home health services are ordered, the hospital must inform its designated case coordination unit, as defined in 89 Ill. Adm. Code 240.260, of the pending discharge and must provide the patient with the case coordination unit's telephone number and other contact information.

(b) Every hospital shall develop procedures for a physician with medical staff privileges at the hospital or any appropriate medical staff member to provide the discharge notice prescribed in subsection (a) of this Section. The procedures must include prohibitions against discharging or

referring a patient to any of the following if unlicensed, uncertified, or unregistered: (i) a board and care facility, as defined in the Board and Care Home Act; (ii) an assisted living and shared housing establishment, as defined in the Assisted Living and Shared Housing Act; (iii) a facility licensed under the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act of 2013, or the ID/DD Community Care Act; (iv) a supportive living facility, as defined in Section 5-5.01a of the Illinois Public Aid Code; or (v) a free-standing hospice facility licensed under the Hospice Program Licensing Act if licensure, certification, or registration is required. The Department of Public Health shall annually provide hospitals with a list of licensed, certified, or registered board and care facilities, assisted living and shared housing establishments, nursing homes, supportive living facilities, facilities licensed under the ID/DD Community Care Act or the Specialized Mental Health Rehabilitation Act of 2013, and hospice facilities. Reliance upon this list by a hospital shall satisfy compliance with this requirement. The procedure may also include a waiver for any case in which a discharge notice is not feasible due to a short length of stay in the hospital by the patient, or for any case in which the patient voluntarily desires to leave the hospital before the expiration of the 24 hour period.

(c) At least 24 hours prior to discharge from the hospital, the patient shall receive written information on the patient's

right to appeal the discharge pursuant to the federal Medicare program, including the steps to follow to appeal the discharge and the appropriate telephone number to call in case the patient intends to appeal the discharge.

(d) Before transfer of a patient to a long term care facility licensed under the Nursing Home Care Act where elderly persons reside, a hospital shall as soon as practicable initiate a name-based criminal history background check by electronic submission to the Department of State Police for all persons between the ages of 18 and 70 years; provided, however, that a hospital shall be required to initiate such a background check only with respect to patients who:

(1) are transferring to a long term care facility for the first time;

(2) have been in the hospital more than 5 days;

(3) are reasonably expected to remain at the long term care facility for more than 30 days;

(4) have a known history of serious mental illness or substance abuse; and

(5) are independently ambulatory or mobile for more than a temporary period of time.

A hospital may also request a criminal history background check for a patient who does not meet any of the criteria set forth in items (1) through (5).

A hospital shall notify a long term care facility if the hospital has initiated a criminal history background check on a

patient being discharged to that facility. In all circumstances in which the hospital is required by this subsection to initiate the criminal history background check, the transfer to the long term care facility may proceed regardless of the availability of criminal history results. Upon receipt of the results, the hospital shall promptly forward the results to the appropriate long term care facility. If the results of the background check are inconclusive, the hospital shall have no additional duty or obligation to seek additional information from, or about, the patient.

(Source: P.A. 97-38, eff. 6-28-11; 97-227, eff. 1-1-12; 97-813, eff. 7-13-12; 98-104, eff. 7-22-13.)

Section 35-10. The Illinois Public Aid Code is amended by changing Section 11-5.4 as follows:

(305 ILCS 5/11-5.4)

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

(a) An expedited long-term care eligibility determination and enrollment system shall be established to reduce long-term care determinations to 90 days or fewer by July 1, 2014 and streamline the long-term care enrollment process. Establishment of the system shall be a joint venture of the Department of Human Services and Healthcare and Family Services and the Department on Aging. The Governor shall name a lead

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

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

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

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

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

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

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

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

(1) The Departments shall review, in collaboration

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

(2) No later than June 30, 2014, the Department of Healthcare and Family Services shall issue vouchers for advance payments not to exceed $50,000,000 to nursing facilities with significant outstanding Medicaid liability associated with services provided to residents with Medicaid applications pending and residents facing the greatest delays. Each facility with an advance payment shall state in writing whether its own recoupment schedule will be in 3 or 6 equal monthly installments, as long as all advances are recouped by June 30, 2015.

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

on this subsection. If found eligible upon review, such applicants shall be retroactively enrolled.

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

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

15, 2014.

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

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

(8) Notwithstanding any other provision of this Code, the Department of Human Services and the Department of Healthcare and Family Services' Office of the Inspector General shall, upon request, allow an applicant additional

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

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

specify the number of applications pending long-term care eligibility determination and admission in the following categories:

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

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

(C) Status of pending applications.

(Source: P.A. 98-104, eff. 7-22-13.)

Article 40

Section 40-5. The Illinois Public Aid Code is amended by changing Sections 5A-2, 5A-5, 5A-10, and 5A-14 as follows:

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

(Section scheduled to be repealed on January 1, 2015)

Sec. 5A-2. Assessment.

(a) Subject to Sections 5A-3 and 5A-10, for State fiscal years 2009 through 2018 ~~2014, and from July 1, 2014 through December 31, 2014~~, an annual assessment on inpatient services is imposed on each hospital provider in an amount equal to $218.38 multiplied by the difference of the hospital's occupied bed days less the hospital's Medicare bed days, provided, however, that the amount of $218.38 shall be increased by a uniform percentage to generate an amount equal to 75% of the State share of the payments authorized under Section 12-5, with such increase only taking effect upon the date that a State share for such payments is required under federal law.

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

(b) (Blank).

(b-5) Subject to Sections 5A-3 and 5A-10, for the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018 ~~2014, and July 1, 2014 through December 31, 2014~~, an annual assessment on outpatient services is imposed on each hospital provider in an amount equal to .008766 multiplied by the hospital's outpatient gross revenue, provided, however, that the amount of .008766 shall be increased by a uniform percentage to generate an amount equal to 25% of the State share of the payments authorized under Section 12-5, with such increase only taking effect upon the date that a State share for such payments is required under federal law. For the period beginning June 10, 2012 through June 30, 2012, the annual assessment on outpatient services shall be prorated by multiplying the assessment amount by a fraction, the numerator of which is 21 days and the denominator of which is 365 days.

For the portion of State fiscal year 2012, beginning June 10, 2012 through June 30, 2012, and State fiscal years 2013 through 2018 ~~2014, and July 1, 2014 through December 31, 2014~~, a hospital's outpatient gross revenue shall be determined using the most recent data available from each hospital's 2009 Medicare cost report as contained in the Healthcare Cost Report Information System file, for the quarter ending on June 30, 2011, without regard to any subsequent adjustments or changes to such data. If a hospital's 2009 Medicare cost report is not

contained in the Healthcare Cost Report Information System, then the Department may obtain the hospital provider's outpatient gross revenue from any source available, including, but not limited to, records maintained by the hospital provider, which may be inspected at all times during business hours of the day by the Department or its duly authorized agents and employees.

(c) (Blank).

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

(e) Notwithstanding any other provision of this Section, any plan providing for an assessment on a hospital provider as a permissible tax under Title XIX of the federal Social Security Act and Medicaid-eligible payments to hospital providers from the revenues derived from that assessment shall be reviewed by the Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency required by federal law, to determine whether those assessments and hospital provider payments meet federal Medicaid standards. If the Department determines that the elements of the plan may meet federal Medicaid standards and a related State Medicaid Plan Amendment is prepared in a manner and form suitable for submission, that State Plan Amendment shall be submitted in a

timely manner for review by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and subject to approval by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. No such plan shall become effective without approval by the Illinois General Assembly by the enactment into law of related legislation. Notwithstanding any other provision of this Section, the Department is authorized to adopt rules to reduce the rate of any annual assessment imposed under this Section. Any such rules may be adopted by the Department under Section 5-50 of the Illinois Administrative Procedure Act.

(Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12; 98-104, eff. 7-22-13.)

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

Sec. 5A-5. Notice; penalty; maintenance of records.

(a) The Illinois Department shall send a notice of assessment to every hospital provider subject to assessment under this Article. The notice of assessment shall notify the hospital of its assessment and shall be sent after receipt by the Department of notification from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services that the payment methodologies required under this Article and, if necessary, the waiver granted under 42 CFR 433.68 have been approved. The notice shall be on a form

prepared by the Illinois Department and shall state the following:

(1) The name of the hospital provider.

(2) The address of the hospital provider's principal place of business from which the provider engages in the occupation of hospital provider in this State, and the name and address of each hospital operated, conducted, or maintained by the provider in this State.

(3) The occupied bed days, occupied bed days less Medicare days, adjusted gross hospital revenue, or outpatient gross revenue of the hospital provider (whichever is applicable), the amount of assessment imposed under Section 5A-2 for the State fiscal year for which the notice is sent, and the amount of each installment to be paid during the State fiscal year.

(4) (Blank).

(5) Other reasonable information as determined by the Illinois Department.

(b) If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, the provider shall pay the assessment for each hospital separately.

(c) Notwithstanding any other provision in this Article, in the case of a person who ceases to conduct, operate, or maintain a hospital in respect of which the person is subject to assessment under this Article as a hospital provider, the

assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under Section 5A-2 by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. Immediately upon ceasing to conduct, operate, or maintain a hospital, the person shall pay the assessment for the year as so adjusted (to the extent not previously paid).

(d) Notwithstanding any other provision in this Article, a provider who commences conducting, operating, or maintaining a hospital, upon notice by the Illinois Department, shall pay the assessment computed under Section 5A-2 and subsection (e) in installments on the due dates stated in the notice and on the regular installment due dates for the State fiscal year occurring after the due dates of the initial notice.

(e) Notwithstanding any other provision in this Article, for State fiscal years 2009 through 2018 ~~2014~~, in the case of a hospital provider that did not conduct, operate, or maintain a hospital in 2005, the assessment for that State fiscal year shall be computed on the basis of hypothetical occupied bed days for the full calendar year as determined by the Illinois Department. Notwithstanding any other provision in this Article, for the portion of State fiscal year 2012 beginning June 10, 2012 through June 30, 2012, and for State fiscal years 2013 through 2018 ~~2014, and for July 1, 2014 through December 31, 2014~~, in the case of a hospital provider that did not

conduct, operate, or maintain a hospital in 2009, the assessment under subsection (b-5) of Section 5A-2 for that State fiscal year shall be computed on the basis of hypothetical gross outpatient revenue for the full calendar year as determined by the Illinois Department.

(f) Every hospital provider subject to assessment under this Article shall keep sufficient records to permit the determination of adjusted gross hospital revenue for the hospital's fiscal year. All such records shall be kept in the English language and shall, at all times during regular business hours of the day, be subject to inspection by the Illinois Department or its duly authorized agents and employees.

(g) The Illinois Department may, by rule, provide a hospital provider a reasonable opportunity to request a clarification or correction of any clerical or computational errors contained in the calculation of its assessment, but such corrections shall not extend to updating the cost report information used to calculate the assessment.

(h) (Blank).

(Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12; 98-104, eff. 7-22-13; 98-463, eff. 8-16-13; revised 10-21-13.)

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

Sec. 5A-10. Applicability.

(a) The assessment imposed by subsection (a) of Section

5A-2 shall cease to be imposed and the Department's obligation to make payments shall immediately cease, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by them, if:

(1) The payments to hospitals required under this Article are not eligible for federal matching funds under Title XIX or XXI of the Social Security Act;

(2) For State fiscal years 2009 through 2018 ~~2014, and July 1, 2014 through December 31, 2014~~, the Department of Healthcare and Family Services adopts any administrative rule change to reduce payment rates or alters any payment methodology that reduces any payment rates made to operating hospitals under the approved Title XIX or Title XXI State plan in effect January 1, 2008 except for:

(A) any changes for hospitals described in subsection (b) of Section 5A-3;

(B) any rates for payments made under this Article V-A;

(C) any changes proposed in State plan amendment transmittal numbers 08-01, 08-02, 08-04, 08-06, and 08-07;

(D) in relation to any admissions on or after January 1, 2011, a modification in the methodology for calculating outlier payments to hospitals for exceptionally costly stays, for hospitals reimbursed under the diagnosis-related grouping methodology in

effect on July 1, 2011; provided that the Department shall be limited to one such modification during the 36-month period after the effective date of this amendatory Act of the 96th General Assembly; ~~or~~

(E) any changes affecting hospitals authorized by Public Act 97-689; or ~~.~~

(F) any changes authorized by Section 14-12 of this Code, or for any changes authorized under Section 5A-15 of this Code.

(b) The assessment imposed by Section 5A-2 shall not take effect or shall cease to be imposed, and the Department's obligation to make payments shall immediately cease, if the assessment is determined to be an impermissible tax under Title XIX of the Social Security Act. Moneys in the Hospital Provider Fund derived from assessments imposed prior thereto shall be disbursed in accordance with Section 5A-8 to the extent federal financial participation is not reduced due to the impermissibility of the assessments, and any remaining moneys shall be refunded to hospital providers in proportion to the amounts paid by them.

(c) The assessments imposed by subsection (b-5) of Section 5A-2 shall not take effect or shall cease to be imposed, the Department's obligation to make payments shall immediately cease, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by them, if the payments to hospitals required under Section

5A-12.4 are not eligible for federal matching funds under Title XIX of the Social Security Act.

(d) The assessments imposed by Section 5A-2 shall not take effect or shall cease to be imposed, the Department's obligation to make payments shall immediately cease, and any moneys remaining in the Fund shall be refunded to hospital providers in proportion to the amounts paid by them, if:

(1) for State fiscal years 2013 through 2018 ~~2014, and July 1, 2014 through December 31, 2014~~, the Department reduces any payment rates to hospitals as in effect on May 1, 2012, or alters any payment methodology as in effect on May 1, 2012, that has the effect of reducing payment rates to hospitals, except for any changes affecting hospitals authorized in Public Act 97-689 and any changes authorized by Section 14-12 of this Code, and except for any changes authorized under Section 5A-15; ~~or~~

(2) for State fiscal years 2013 through 2018 ~~2014, and July 1, 2014 through December 31, 2014~~, the Department reduces any supplemental payments made to hospitals below the amounts paid for services provided in State fiscal year 2011 as implemented by administrative rules adopted and in effect on or prior to June 30, 2011, except for any changes affecting hospitals authorized in Public Act 97-689 and any changes authorized by Section 14-12 of this Code, and except for any changes authorized under Section 5A-15; or ~~.~~

(3) for State fiscal years 2015 through 2018, the

Department reduces the overall effective rate of reimbursement to hospitals below the level authorized under Section 14-12 of this Code, except for any changes under Section 14-12 or Section 5A-15 of this Code.

(Source: P.A. 97-72, eff. 7-1-11; 97-74, eff. 6-30-11; 97-688, eff. 6-14-12; 97-689, eff. 6-14-12; 98-463, eff. 8-16-13.)

(305 ILCS 5/5A-14)

Sec. 5A-14. Repeal of assessments and disbursements.

(a) Section 5A-2 is repealed on July 1, 2018 ~~January 1, 2015~~.

(b) Section 5A-12 is repealed on July 1, 2005.

(c) Section 5A-12.1 is repealed on July 1, 2008.

(d) Section 5A-12.2 and Section 5A-12.4 are repealed on July 1, 2018 ~~January 1, 2015~~.

(e) Section 5A-12.3 is repealed on July 1, 2011.

(Source: P.A. 96-821, eff. 11-20-09; 96-1530, eff. 2-16-11; 97-688, eff. 6-14-12; 97-689, eff. 6-14-12.)

Article 45

Section 45-5. The Illinois Public Aid Code is amended by changing Section 14-8 and by adding Section 14-12 as follows:

(305 ILCS 5/14-8) (from Ch. 23, par. 14-8)

Sec. 14-8. Disbursements to Hospitals.

(a) For inpatient hospital services rendered on and after September 1, 1991, the Illinois Department shall reimburse hospitals for inpatient services at an inpatient payment rate calculated for each hospital based upon the Medicare Prospective Payment System as set forth in Sections 1886(b), (d), (g), and (h) of the federal Social Security Act, and the regulations, policies, and procedures promulgated thereunder, except as modified by this Section. Payment rates for inpatient hospital services rendered on or after September 1, 1991 and on or before September 30, 1992 shall be calculated using the Medicare Prospective Payment rates in effect on September 1, 1991. Payment rates for inpatient hospital services rendered on or after October 1, 1992 and on or before March 31, 1994 shall be calculated using the Medicare Prospective Payment rates in effect on September 1, 1992. Payment rates for inpatient hospital services rendered on or after April 1, 1994 shall be calculated using the Medicare Prospective Payment rates (including the Medicare grouping methodology and weighting factors as adjusted pursuant to paragraph (1) of this subsection) in effect 90 days prior to the date of admission. For services rendered on or after July 1, 1995, the reimbursement methodology implemented under this subsection shall not include those costs referred to in Sections 1886(d)(5)(B) and 1886(h) of the Social Security Act. The additional payment amounts required under Section 1886(d)(5)(F) of the Social Security Act, for hospitals serving

a disproportionate share of low-income or indigent patients, are not required under this Section. For hospital inpatient services rendered on or after July 1, 1995 and on or before June 30, 2014, the Illinois Department shall reimburse hospitals using the relative weighting factors and the base payment rates calculated for each hospital that were in effect on June 30, 1995, less the portion of such rates attributed by the Illinois Department to the cost of medical education.

(1) The weighting factors established under Section 1886(d)(4) of the Social Security Act shall not be used in the reimbursement system established under this Section. Rather, the Illinois Department shall establish by rule Medicaid weighting factors to be used in the reimbursement system established under this Section.

(2) The Illinois Department shall define by rule those hospitals or distinct parts of hospitals that shall be exempt from the reimbursement system established under this Section. In defining such hospitals, the Illinois Department shall take into consideration those hospitals exempt from the Medicare Prospective Payment System as of September 1, 1991. For hospitals defined as exempt under this subsection, the Illinois Department shall by rule establish a reimbursement system for payment of inpatient hospital services rendered on and after September 1, 1991. For all hospitals that are children's hospitals as defined in Section 5-5.02 of this Code, the reimbursement

methodology shall, through June 30, 1992, net of all applicable fees, at least equal each children's hospital 1990 ICARE payment rates, indexed to the current year by application of the DRI hospital cost index from 1989 to the year in which payments are made. Excepting county providers as defined in Article XV of this Code, hospitals licensed under the University of Illinois Hospital Act, and facilities operated by the Department of Mental Health and Developmental Disabilities (or its successor, the Department of Human Services) for hospital inpatient services rendered on or after July 1, 1995 and on or before June 30, 2014, the Illinois Department shall reimburse children's hospitals, as defined in 89 Illinois Administrative Code Section 149.50(c)(3), at the rates in effect on June 30, 1995, and shall reimburse all other hospitals at the rates in effect on June 30, 1995, less the portion of such rates attributed by the Illinois Department to the cost of medical education. For inpatient hospital services provided on or after August 1, 1998, the Illinois Department may establish by rule a means of adjusting the rates of children's hospitals, as defined in 89 Illinois Administrative Code Section 149.50(c)(3), that did not meet that definition on June 30, 1995, in order for the inpatient hospital rates of such hospitals to take into account the average inpatient hospital rates of those children's hospitals that did meet the definition of

children's hospitals on June 30, 1995.

(3) (Blank).

(4) Notwithstanding any other provision of this Section, hospitals that on August 31, 1991, have a contract with the Illinois Department under Section 3-4 of the Illinois Health Finance Reform Act may elect to continue to be reimbursed at rates stated in such contracts for general and specialty care.

(5) In addition to any payments made under this subsection (a), the Illinois Department shall make the adjustment payments required by Section 5-5.02 of this Code; provided, that in the case of any hospital reimbursed under a per case methodology, the Illinois Department shall add an amount equal to the product of the hospital's average length of stay, less one day, multiplied by 20, for inpatient hospital services rendered on or after September 1, 1991 and on or before September 30, 1992.

(b) (Blank).

(b-5) Excepting county providers as defined in Article XV of this Code, hospitals licensed under the University of Illinois Hospital Act, and facilities operated by the Illinois Department of Mental Health and Developmental Disabilities (or its successor, the Department of Human Services), for outpatient services rendered on or after July 1, 1995 and before July 1, 1998 the Illinois Department shall reimburse children's hospitals, as defined in the Illinois

Administrative Code Section 149.50(c)(3), at the rates in effect on June 30, 1995, less that portion of such rates attributed by the Illinois Department to the outpatient indigent volume adjustment and shall reimburse all other hospitals at the rates in effect on June 30, 1995, less the portions of such rates attributed by the Illinois Department to the cost of medical education and attributed by the Illinois Department to the outpatient indigent volume adjustment. For outpatient services provided on or after July 1, 1998 and on or before June 30, 2014, reimbursement rates shall be established by rule.

(c) In addition to any other payments under this Code, the Illinois Department shall develop a hospital disproportionate share reimbursement methodology that, effective July 1, 1991, through September 30, 1992, shall reimburse hospitals sufficiently to expend the fee monies described in subsection (b) of Section 14-3 of this Code and the federal matching funds received by the Illinois Department as a result of expenditures made by the Illinois Department as required by this subsection (c) and Section 14-2 that are attributable to fee monies deposited in the Fund, less amounts applied to adjustment payments under Section 5-5.02.

(d) Critical Care Access Payments.

(1) In addition to any other payments made under this Code, the Illinois Department shall develop a reimbursement methodology that shall reimburse Critical

Care Access Hospitals for the specialized services that qualify them as Critical Care Access Hospitals. No adjustment payments shall be made under this subsection on or after July 1, 1995.

(2) "Critical Care Access Hospitals" includes, but is not limited to, hospitals that meet at least one of the following criteria:

(A) Hospitals located outside of a metropolitan statistical area that are designated as Level II Perinatal Centers and that provide a disproportionate share of perinatal services to recipients; or

(B) Hospitals that are designated as Level I Trauma Centers (adult or pediatric) and certain Level II Trauma Centers as determined by the Illinois Department; or

(C) Hospitals located outside of a metropolitan statistical area and that provide a disproportionate share of obstetrical services to recipients.

(e) Inpatient high volume adjustment. For hospital inpatient services, effective with rate periods beginning on or after October 1, 1993, in addition to rates paid for inpatient services by the Illinois Department, the Illinois Department shall make adjustment payments for inpatient services furnished by Medicaid high volume hospitals. The Illinois Department shall establish by rule criteria for qualifying as a Medicaid high volume hospital and shall establish by rule a

reimbursement methodology for calculating these adjustment payments to Medicaid high volume hospitals. No adjustment payment shall be made under this subsection for services rendered on or after July 1, 1995.

(f) The Illinois Department shall modify its current rules governing adjustment payments for targeted access, critical care access, and uncompensated care to classify those adjustment payments as not being payments to disproportionate share hospitals under Title XIX of the federal Social Security Act. Rules adopted under this subsection shall not be effective with respect to services rendered on or after July 1, 1995. The Illinois Department has no obligation to adopt or implement any rules or make any payments under this subsection for services rendered on or after July 1, 1995.

(f-5) The State recognizes that adjustment payments to hospitals providing certain services or incurring certain costs may be necessary to assure that recipients of medical assistance have adequate access to necessary medical services. These adjustments include payments for teaching costs and uncompensated care, trauma center payments, rehabilitation hospital payments, perinatal center payments, obstetrical care payments, targeted access payments, Medicaid high volume payments, and outpatient indigent volume payments. On or before April 1, 1995, the Illinois Department shall issue recommendations regarding (i) reimbursement mechanisms or adjustment payments to reflect these costs and services,

including methods by which the payments may be calculated and the method by which the payments may be financed, and (ii) reimbursement mechanisms or adjustment payments to reflect costs and services of federally qualified health centers with respect to recipients of medical assistance.

(g) If one or more hospitals file suit in any court challenging any part of this Article XIV, payments to hospitals under this Article XIV shall be made only to the extent that sufficient monies are available in the Fund and only to the extent that any monies in the Fund are not prohibited from disbursement under any order of the court.

(h) Payments under the disbursement methodology described in this Section are subject to approval by the federal government in an appropriate State plan amendment.

(i) The Illinois Department may by rule establish criteria for and develop methodologies for adjustment payments to hospitals participating under this Article.

(j) Hospital Residing Long Term Care Services. In addition to any other payments made under this Code, the Illinois Department may by rule establish criteria and develop methodologies for payments to hospitals for Hospital Residing Long Term Care Services.

(k) Critical Access Hospital outpatient payments. In addition to any other payments authorized under this Code, the Illinois Department shall reimburse critical access hospitals, as designated by the Illinois Department of Public Health in

accordance with 42 CFR 485, Subpart F, for outpatient services at an amount that is no less than the cost of providing such services, based on Medicare cost principles. Payments under this subsection shall be subject to appropriation.

(l) 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. 97-689, eff. 6-14-12; 98-463, eff. 8-16-13.)

(305 ILCS 5/14-12 new)

Sec. 14-12. Hospital rate reform payment system. The hospital payment system pursuant to Section 14-11 of this Article shall be as follows:

(a) Inpatient hospital services. Effective for discharges on and after July 1, 2014, reimbursement for inpatient general acute care services shall utilize the All Patient Refined Diagnosis Related Grouping (APR-DRG) software, version 30, distributed by 3M™ Health Information System.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. Initial weighting factors shall be the weighting factors as published by 3M Health Information System, associated with Version 30.0 adjusted for the Illinois experience.

(2) The Department shall establish a statewide-standardized amount to be used in the inpatient reimbursement system. The Department shall publish these amounts on its website no later than 10 calendar days prior to their effective date.

(3) In addition to the statewide-standardized amount, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid providers or services for trauma, transplantation services, perinatal care, and Graduate Medical Education (GME).

(4) The Department shall develop add-on payments to account for exceptionally costly inpatient stays, consistent with Medicare outlier principles. Outlier fixed loss thresholds may be updated to control for excessive growth in outlier payments no more frequently than on an annual basis, but at least triennially. Upon updating the fixed loss thresholds, the Department shall be required to update base rates within 12 months.

(5) The Department shall define those hospitals or distinct parts of hospitals that shall be exempt from the APR-DRG reimbursement system established under this Section. The Department shall publish these hospitals' inpatient rates on its website no later than 10 calendar days prior to their effective date.

(6) Beginning July 1, 2014 and ending on June 30, 2018, in addition to the statewide-standardized amount, the

Department shall develop an adjustor to adjust the rate of reimbursement for safety-net hospitals defined in Section 5-5e.1 of this Code excluding pediatric hospitals.

(7) Beginning July 1, 2014 and ending on June 30, 2018, in addition to the statewide-standardized amount, the Department shall develop an adjustor to adjust the rate of reimbursement for Illinois freestanding inpatient psychiatric hospitals that are not designated as children's hospitals by the Department but are primarily treating patients under the age of 21.

(b) Outpatient hospital services. Effective for dates of service on and after July 1, 2014, reimbursement for outpatient services shall utilize the Enhanced Ambulatory Procedure Grouping (E-APG) software, version 3.7 distributed by 3M™ Health Information System.

(1) The Department shall establish Medicaid weighting factors to be used in the reimbursement system established under this subsection. The initial weighting factors shall be the weighting factors as published by 3M Health Information System, associated with Version 3.7.

(2) The Department shall establish service specific statewide-standardized amounts to be used in the reimbursement system.

(A) The initial statewide standardized amounts, with the labor portion adjusted by the Calendar Year 2013 Medicare Outpatient Prospective Payment System

wage index with reclassifications, shall be published by the Department on its website no later than 10 calendar days prior to their effective date.

(B) The Department shall establish adjustments to the statewide-standardized amounts for each Critical Access Hospital, as designated by the Department of Public Health in accordance with 42 CFR 485, Subpart F. The EAPG standardized amounts are determined separately for each critical access hospital such that simulated EAPG payments using outpatient base period paid claim data plus payments under Section 5A-12.4 of this Code net of the associated tax costs are equal to the estimated costs of outpatient base period claims data with a rate year cost inflation factor applied.

(3) In addition to the statewide-standardized amounts, the Department shall develop adjusters to adjust the rate of reimbursement for critical Medicaid hospital outpatient providers or services, including outpatient high volume or safety-net hospitals.

(c) In consultation with the hospital community, the Department is authorized to replace 89 Ill. Admin. Code 152.150 as published in 38 Ill. Reg. 4980 through 4986 within 12 months of the effective date of this amendatory Act of the 98th General Assembly. If the Department does not replace these rules within 12 months of the effective date of this amendatory Act of the 98th General Assembly, the rules in effect for

152.150 as published in 38 Ill. Reg. 4980 through 4986 shall remain in effect until modified by rule by the Department. Nothing in this subsection shall be construed to mandate that the Department file a replacement rule.

(d) Transition period. There shall be a transition period to the reimbursement systems authorized under this Section that shall begin on the effective date of these systems and continue until June 30, 2018, unless extended by rule by the Department. To help provide an orderly and predictable transition to the new reimbursement systems and to preserve and enhance access to the hospital services during this transition, the Department shall allocate a transitional hospital access pool of at least $290,000,000 annually so that transitional hospital access payments are made to hospitals.

(1) After the transition period, the Department may begin incorporating the transitional hospital access pool into the base rate structure.

(2) After the transition period, if the Department reduces payments from the transitional hospital access pool, it shall increase base rates, develop new adjustors, adjust current adjustors, develop new hospital access payments based on updated information, or any combination thereof by an amount equal to the decreases proposed in the transitional hospital access pool payments, ensuring that the entire transitional hospital access pool amount shall continue to be used for hospital payments.

(e) Beginning 36 months after initial implementation, the Department shall update the reimbursement components in subsections (a) and (b), including standardized amounts and weighting factors, and at least triennially and no more frequently than annually thereafter. The Department shall publish these updates on its website no later than 30 calendar days prior to their effective date.

(f) Continuation of supplemental payments. Any supplemental payments authorized under Illinois Administrative Code 148 effective January 1, 2014 and that continue during the period of July 1, 2014 through December 31, 2014 shall remain in effect as long as the assessment imposed by Section 5A-2 is in effect.

(g) Notwithstanding subsections (a) through (f) of this Section, any updates to the system shall not result in any diminishment of the overall effective rates of reimbursement as of the implementation date of the new system (July 1, 2014). These updates shall not preclude variations in any individual component of the system or hospital rate variations. Nothing in this Section shall prohibit the Department from increasing the rates of reimbursement or developing payments to ensure access to hospital services. Nothing in this Section shall be construed to guarantee a minimum amount of spending in the aggregate or per hospital as spending may be impacted by factors including but not limited to the number of individuals in the medical assistance program and the severity of illness

of the individuals.

(h) The Department shall have the authority to modify by rulemaking any changes to the rates or methodologies in this Section as required by the federal government to obtain federal financial participation for expenditures made under this Section.

(i) Except for subsections (g) and (h) of this Section, the Department shall, pursuant to subsection (c) of Section 5-40 of the Illinois Administrative Procedure Act, provide for presentation at the June 2014 hearing of the Joint Committee on Administrative Rules (JCAR) additional written notice to JCAR of the following rules in order to commence the second notice period for the following rules: rules published in the Illinois Register, rule dated February 21, 2014 at 38 Ill. Reg. 4559 (Medical Payment), 4628 (Specialized Health Care Delivery Systems), 4640 (Hospital Services), 4932 (Diagnostic Related Grouping (DRG) Prospective Payment System (PPS)), and 4977 (Hospital Reimbursement Changes), and published in the Illinois Register dated March 21, 2014 at 38 Ill. Reg. 6499 (Specialized Health Care Delivery Systems) and 6505 (Hospital Services).

Article 50

Section 50-5. The Specialized Mental Health Rehabilitation Act of 2013 is amended by changing Sections 3-116 and 3-205 as

follows:

(210 ILCS 49/3-116)

Sec. 3-116. Experimental research. No consumer shall be subjected to experimental research or treatment without first obtaining his or her informed, written consent. The conduct of any experimental research or treatment shall be authorized and monitored by an institutional review board appointed by the Director of the Department ~~executive director~~. The membership, operating procedures and review criteria for the institutional review board shall be prescribed under rules and regulations of the Department and shall comply with the requirements for institutional review boards established by the federal Food and Drug Administration. No person who has received compensation in the prior 3 years from an entity that manufactures, distributes, or sells pharmaceuticals, biologics, or medical devices may serve on the institutional review board.

No facility shall permit experimental research or treatment to be conducted on a consumer, or give access to any person or person's records for a retrospective study about the safety or efficacy of any care or treatment, without the prior written approval of the institutional review board. No executive director, or person licensed by the State to provide medical care or treatment to any person, may assist or participate in any experimental research on or treatment of a consumer, including a retrospective study, that does not have

the prior written approval of the board. Such conduct shall be grounds for professional discipline by the Department of Financial and Professional Regulation.

The institutional review board may exempt from ongoing review research or treatment initiated on a consumer before the individual's admission to a facility and for which the board determines there is adequate ongoing oversight by another institutional review board. Nothing in this Section shall prevent a facility, any facility employee, or any other person from assisting or participating in any experimental research on or treatment of a consumer, if the research or treatment began before the person's admission to a facility, until the board has reviewed the research or treatment and decided to grant or deny approval or to exempt the research or treatment from ongoing review.

(Source: P.A. 98-104, eff. 7-22-13.)

(210 ILCS 49/3-205)

Sec. 3-205. Disclosure of information to public. Standards for the disclosure of information to the public shall be established by rule. These information disclosure standards shall include, but are not limited to, the following: staffing and personnel levels, licensure and inspection information, national accreditation information, consumer charges ~~cost and reimbursement information~~, and consumer complaint information. Rules for the public disclosure of information shall be in

accordance with the provisions for inspection and copying of public records in the Freedom of Information Act. The Department of Healthcare and Family Services shall make facility cost reports available on its website.

(Source: P.A. 98-104, eff. 7-22-13.)

Article 55

Section 55-5. The State Finance Act is amended by adding Section 5.855 as follows:

(30 ILCS 105/5.855 new)

Sec. 5.855. The Supportive Living Facility Fund.

Section 55-10. The Specialized Mental Health Rehabilitation Act of 2013 is amended by adding Section 5-102 as follows:

(210 ILCS 49/5-102 new)

Sec. 5-102. Transition payments. In addition to payments already required by law, the Department of Healthcare and Family Services shall make payments to facilities licensed under this Act in the amount of $29.43 per licensed bed, per day, for the period beginning June 1, 2014 and ending June 30, 2014.

Section 55-15. The Illinois Public Aid Code is amended by changing Sections 5-5, 5-5.01a, 5-5.2, 5-5.4h, 5-5e, 5-5e.1, 5-5f, 5B-1, 5C-1, 5C-2, and 5C-7 and by adding Section 5C-10 and Article V-G as follows:

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and

prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State, but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures are necessary for the preservation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

All screenings shall include a physical breast exam, instruction on self-examination and information regarding the frequency of self-examination and its value as a preventative tool. For purposes of this Section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with an

average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography.

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

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

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

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

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

who meet that goal.

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

Any medical or health care provider shall immediately recommend, to any pregnant woman who is being provided prenatal services and is suspected of drug abuse or is addicted as defined in the Alcoholism and Other Drug Abuse and Dependency Act, referral to a local substance abuse treatment provider licensed by the Department of Human Services or to a licensed hospital which provides substance abuse treatment services. The Department of Healthcare and Family Services shall assure coverage for the cost of treatment of the drug abuse or addiction for pregnant recipients in accordance with the Illinois Medicaid Program in conjunction with the Department of Human Services.

All medical providers providing medical assistance to pregnant women under this Code shall receive information from

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

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

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

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

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

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

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

(2) The Department may elect to consider and negotiate financial incentives to encourage the development of

Partnerships and the efficient delivery of medical care.

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

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

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

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put

into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after the effective date of this amendatory Act of 1984, the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

The rules and regulations of the Illinois Department shall require that a written statement including the required opinion of a physician shall accompany any claim for reimbursement for abortions, or induced miscarriages or premature births. This statement shall indicate what procedures were used in providing such medical services.

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after July 22, 2013, the effective date of Public Act 98-104 ~~this amendatory Act of the 98th General Assembly~~, establish procedures to permit skilled care facilities licensed under the Nursing Home Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department

shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

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

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

Enrollment of a vendor shall be subject to a provisional period and shall be conditional for one year. During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the medical assistance program without cause.

Unless otherwise specified, such termination of eligibility or disenrollment is not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

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

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

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

hearing rights, if any, afforded to a vendor in each category of risk of the vendor that is terminated or disenrolled during the conditional enrollment period.

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

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

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

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

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

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

In the case of long term care facilities, within 5 days of receipt by the facility of required prescreening information, data for new admissions shall be entered into the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System or successor system, and within 15 days of receipt by the facility of required prescreening information, admission documents shall be submitted ~~within 30 days of an admission to the facility~~ through MEDI or REV ~~the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System,~~ or shall be submitted directly to the Department of Human Services using required admission forms. Effective September 1, 2014, admission documents, including all prescreening information, must be submitted through MEDI or REV. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been

completed.

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

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

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Illinois Department shall develop, in cooperation with other State departments and agencies, and in compliance with

applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

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

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and

durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of the recipient's needs, and the requirements and costs for maintaining such equipment. Subject to prior approval, such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department.

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped; and (iii) notwithstanding any other provision of law, subject to federal approval, on and after July 1, 2012, an increase in the determination of need (DON) scores from 29 to 37 for applicants for institutional and home and community-based long term care; if and only if federal approval is not granted, the Department may, in conjunction with other affected agencies, implement

utilization controls or changes in benefit packages to effectuate a similar savings amount for this population; and (iv) no later than July 1, 2013, minimum level of care eligibility criteria for institutional and home and community-based long term care; and (v) no later than October 1, 2013, establish procedures to permit long term care providers access to eligibility scores for individuals with an admission date who are seeking or receiving services from the long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

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

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

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

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

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

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

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

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

whatever reason, is unauthorized.

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

Because kidney transplantation can be an appropriate, cost effective alternative to renal dialysis when medically necessary and notwithstanding the provisions of Section 1-11 of this Code, beginning October 1, 2014, the Department shall cover kidney transplantation for noncitizens with end-stage renal disease who are not eligible for comprehensive medical benefits, who meet the residency requirements of Section 5-3 of this Code, and who would otherwise meet the financial requirements of the appropriate class of eligible persons under Section 5-2 of this Code. To qualify for coverage of kidney transplantation, such person must be receiving emergency renal dialysis services covered by the Department. Providers under this Section shall be prior approved and certified by the Department to perform kidney transplantation and the services under this Section shall be limited to services associated with kidney transplantation.

(Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689, eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; revised

9-19-13.)

(305 ILCS 5/5-5.01a)

Sec. 5-5.01a. Supportive living facilities program. The Department shall establish and provide oversight for a program of supportive living facilities that seek to promote resident independence, dignity, respect, and well-being in the most cost-effective manner.

A supportive living facility is either a free-standing facility or a distinct physical and operational entity within a nursing facility. A supportive living facility integrates housing with health, personal care, and supportive services and is a designated setting that offers residents their own separate, private, and distinct living units.

Sites for the operation of the program shall be selected by the Department based upon criteria that may include the need for services in a geographic area, the availability of funding, and the site's ability to meet the standards.

Beginning July 1, 2014, subject to federal approval, the Medicaid rates for supportive living facilities shall be equal to the supportive living facility Medicaid rate effective on June 30, 2014 increased by 8.85%. Once the assessment imposed at Article V-G of this Code is determined to be a permissible tax under Title XIX of the Social Security Act, the Department shall increase the Medicaid rates for supportive living facilities effective on July 1, 2014 by 9.09%. The Department

shall apply this increase retroactively to coincide with the imposition of the assessment in Article V-G of this Code in accordance with the approval for federal financial participation by the Centers for Medicare and Medicaid Services.

The Department may adopt rules to implement this Section. Rules that establish or modify the services, standards, and conditions for participation in the program shall be adopted by the Department in consultation with the Department on Aging, the Department of Rehabilitation Services, and the Department of Mental Health and Developmental Disabilities (or their successor agencies).

Facilities or distinct parts of facilities which are selected as supportive living facilities and are in good standing with the Department's rules are exempt from the provisions of the Nursing Home Care Act and the Illinois Health Facilities Planning Act.

(Source: P.A. 94-342, eff. 7-26-05.)

(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.

(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.

~~Notwithstanding any other provision of this Code, the Department shall by rule develop a reimbursement methodology reflective of the intensity of care and services requirements of low need residents in the lowest RUG IV groupers and corresponding regulations. Only that portion of the RUGs Reimbursement System spending pool described in subsection (d 1) attributed to the groupers as of July 1, 2013 for which the methodology in this Section is developed may be diverted for this purpose. The Department shall submit the rules no later than January 1, 2014 for an implementation date no later than January 1, 2015.~~

~~If the Department does not implement this reimbursement methodology by the required date, the nursing component per diem on January 1, 2015 for residents classified in RUG-IV groups PA1, PA2, BA1, and BA2 shall be the blended rate of the calculated RUG IV nursing component per diem and the nursing~~

~~component per diem in effect on July 1, 2012. This blended rate shall be applied only to nursing homes whose resident population is greater than or equal to 70% of the total residents served and whose RUG-IV nursing component per diem rate is less than the nursing component per diem in effect on July 1, 2012. This blended rate shall be in effect until the reimbursement methodology is implemented or until July 1, 2019, whichever is sooner.~~

(e-1) (Blank). ~~Notwithstanding any other provision of this Article, rates established pursuant to this subsection shall not apply to any and all nursing facilities designated by the Department as "Institutions for Mental Disease" and shall be excluded from the RUGs Reimbursement System applicable to facilities not designated as "Institutions for the Mentally Diseased" by the Department.~~

(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%.

(Source: P.A. 97-689, eff. 6-14-12; 98-104, Article 6, Section 6-240, eff. 7-22-13; 98-104, Article 11, Section 11-35, eff. 7-22-13; revised 9-19-13.)

(305 ILCS 5/5-5.4h)

Sec. 5-5.4h. Medicaid reimbursement for long-term care facilities for persons under 22 years of age ~~pediatric skilled nursing facilities~~.

(a) Facilities licensed as long-term care facilities for persons under 22 years of age ~~uniquely licensed as pediatric skilled nursing facilities~~ 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, long-term care facilities for persons under 22 years of age ~~pediatric skilled nursing facilities~~ 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 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.

(d) To qualify for the per diem rate of $669 for clinically complex residents on a ventilator pursuant to subsection (c), 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 record.

(e) 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.

(Source: P.A. 98-104, eff. 7-22-13.)

(305 ILCS 5/5-5e)

Sec. 5-5e. Adjusted rates of reimbursement.

(a) Rates or payments for services in effect on June 30, 2012 shall be adjusted and services shall be affected as required by any other provision of this amendatory Act of the 97th General Assembly. In addition, the Department shall do the following:

(1) Delink the per diem rate paid for supportive living facility services from the per diem rate paid for nursing facility services, effective for services provided on or after May 1, 2011.

(2) Cease payment for bed reserves in nursing facilities and specialized mental health rehabilitation facilities.

(2.5) Cease payment for bed reserves for purposes of inpatient hospitalizations to intermediate care facilities for persons with development disabilities, except in the instance of residents who are under 21 years of age.

(3) Cease payment of the $10 per day add-on payment to nursing facilities for certain residents with developmental disabilities.

(b) After the application of subsection (a), notwithstanding any other provision of this Code to the contrary and to the extent permitted by federal law, on and after July 1, 2012, the rates of reimbursement for services and other payments provided under this Code shall further be reduced as follows:

(1) Rates or payments for physician services, dental services, or community health center services reimbursed through an encounter rate, and services provided under the Medicaid Rehabilitation Option of the Illinois Title XIX State Plan shall not be further reduced.

(2) Rates or payments, or the portion thereof, paid to a provider that is operated by a unit of local government or State University that provides the non-federal share of such services shall not be further reduced.

(3) Rates or payments for hospital services delivered by a hospital defined as a Safety-Net Hospital under Section 5-5e.1 of this Code shall not be further reduced.

(4) Rates or payments for hospital services delivered

by a Critical Access Hospital, which is an Illinois hospital designated as a critical care hospital by the Department of Public Health in accordance with 42 CFR 485, Subpart F, shall not be further reduced.

(5) Rates or payments for Nursing Facility Services shall only be further adjusted pursuant to Section 5-5.2 of this Code.

(6) Rates or payments for services delivered by long term care facilities licensed under the ID/DD Community Care Act and developmental training services shall not be further reduced.

(7) Rates or payments for services provided under capitation rates shall be adjusted taking into consideration the rates reduction and covered services required by this amendatory Act of the 97th General Assembly.

(8) For hospitals not previously described in this subsection, the rates or payments for hospital services shall be further reduced by 3.5%, except for payments authorized under Section 5A-12.4 of this Code.

(9) For all other rates or payments for services delivered by providers not specifically referenced in paragraphs (1) through (8), rates or payments shall be further reduced by 2.7%.

(c) Any assessment imposed by this Code shall continue and nothing in this Section shall be construed to cause it to

cease.

(d) Notwithstanding any other provision of this Code to the contrary, subject to federal approval under Title XIX of the Social Security Act, for dates of service on and after July 1, 2014, rates or payments for services provided for the purpose of transitioning children from a hospital to home placement or other appropriate setting by a children's community-based health care center authorized under the Alternative Health Care Delivery Act shall be $683 per day.

(e) Notwithstanding any other provision of this Code to the contrary, subject to federal approval under Title XIX of the Social Security Act, for dates of service on and after July 1, 2014, rates or payments for home health visits shall be $72.

(f) Notwithstanding any other provision of this Code to the contrary, subject to federal approval under Title XIX of the Social Security Act, for dates of service on and after July 1, 2014, rates or payments for the certified nursing assistant component of the home health agency rate shall be $20.

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

(305 ILCS 5/5-5e.1)

Sec. 5-5e.1. Safety-Net Hospitals.

(a) A Safety-Net Hospital is an Illinois hospital that:

(1) is licensed by the Department of Public Health as a general acute care or pediatric hospital; and

(2) is a disproportionate share hospital, as described

in Section 1923 of the federal Social Security Act, as determined by the Department; and

(3) meets one of the following:

(A) has a MIUR of at least 40% and a charity percent of at least 4%; or

(B) has a MIUR of at least 50%.

(b) Definitions. As used in this Section:

(1) "Charity percent" means the ratio of (i) the hospital's charity charges for services provided to individuals without health insurance or another source of third party coverage to (ii) the Illinois total hospital charges, each as reported on the hospital's OBRA form.

(2) "MIUR" means Medicaid Inpatient Utilization Rate and is defined as a fraction, the numerator of which is the number of a hospital's inpatient days provided in the hospital's fiscal year ending 3 years prior to the rate year, to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act, 42 USC 1396a et seq., excluding those persons eligible for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of Section 5-2 of this Article, and the denominator of which is the total number of the hospital's inpatient days in that same period, excluding those persons eligible for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) as set forth in paragraph 18 of

Section 5-2 of this Article.

(3) "OBRA form" means form HFS-3834, OBRA '93 data collection form, for the rate year.

(4) "Rate year" means the 12-month period beginning on October 1.

(c) Beginning July 1, 2012 and ending on June 30, 2018, ~~For the 27 month period beginning July 1, 2012,~~ a hospital that would have qualified for the rate year beginning October 1, 2011, shall be a Safety-Net Hospital.

(d) No later than August 15 preceding the rate year, each hospital shall submit the OBRA form to the Department. Prior to October 1, the Department shall notify each hospital whether it has qualified as a Safety-Net Hospital.

(e) The Department may promulgate rules in order to implement this Section.

(f) Nothing in this Section shall be construed as limiting the ability of the Department to include the Safety-Net Hospitals in the hospital rate reform mandated by Section 14-11 of this Code and implemented under Section 14-12 of this Code and by administrative rulemaking.

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

(305 ILCS 5/5-5f)

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

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

(b) The Department shall place the following limitations on services: (i) the Department shall limit adult eyeglasses to one pair every 2 years; (ii) the Department shall set an annual limit of a maximum of 20 visits for each of the following services: adult speech, hearing, and language therapy services, adult occupational therapy services, and physical therapy services; on or after October 1, 2014, the annual maximum limit of 20 visits shall expire but the Department shall require prior approval for all individuals for speech, hearing, and language therapy services, occupational therapy services, and physical therapy services; (iii) the Department shall limit adult podiatry services to individuals with diabetes; on or after October 1, 2014, podiatry services shall not be limited to individuals with diabetes; (iv) the Department shall pay for caesarean sections at the normal vaginal delivery rate unless a caesarean section was medically necessary; (v) the Department shall limit adult dental services to emergencies; beginning July 1, 2013, the Department shall ensure that the following conditions are recognized as emergencies: (A) dental services necessary for an individual in order for the individual to be cleared for a medical procedure,

such as a transplant; (B) extractions and dentures necessary for a diabetic to receive proper nutrition; (C) extractions and dentures necessary as a result of cancer treatment; and (D) dental services necessary for the health of a pregnant woman prior to delivery of her baby; on or after July 1, 2014, adult dental services shall no longer be limited to emergencies, and dental services necessary for the health of a pregnant woman prior to delivery of her baby shall continue to be covered; and (vi) effective July 1, 2012, the Department shall place limitations and require concurrent review on every inpatient detoxification stay to prevent repeat admissions to any hospital for detoxification within 60 days of a previous inpatient detoxification stay. The Department shall convene a workgroup of hospitals, substance abuse providers, care coordination entities, managed care plans, and other stakeholders to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification, which shall be published on the Department's website no later than September 1, 2013.

(c) The Department shall require prior approval of the following services: wheelchair repairs costing more than $400, coronary artery bypass graft, and bariatric surgery consistent with Medicare standards concerning patient responsibility. Wheelchair repair prior approval requests shall be adjudicated within one business day of receipt of complete supporting

documentation. Providers may not break wheelchair repairs into separate claims for purposes of staying under the $400 threshold for requiring prior approval. The wholesale price of manual and power wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

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

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

(f) For home health services, the Department shall require Medicare certification of providers participating in the

program and implement the Medicare face-to-face encounter rule. The Department shall require providers to implement auditable electronic service verification based on global positioning systems or other cost-effective technology.

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

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

As used in this subsection (h):

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

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

(i) The Department shall implement cost savings initiatives for advanced imaging services, cardiac imaging services, pain management services, and back surgery. Such initiatives shall be designed to achieve annual costs savings.

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

(Source: P.A. 97-689, eff. 6-14-12; 98-104, Article 6, Section 6-240, eff. 7-22-13; 98-104, Article 9, Section 9-5, eff. 7-22-13; revised 9-19-13.)

(305 ILCS 5/5B-1) (from Ch. 23, par. 5B-1)

Sec. 5B-1. Definitions. As used in this Article, unless the context requires otherwise:

"Fund" means the Long-Term Care Provider Fund.

"Long-term care facility" means (i) a nursing facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act or the ID/DD Community Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code, and (ii) a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided; except that the term "long-term care facility" does not include a facility operated by a State agency or operated solely as an

intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act.

"Long-term care provider" means (i) a person licensed by the Department of Public Health to operate and maintain a skilled nursing or intermediate long-term care facility or (ii) a hospital provider that provides skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act. For purposes of this paragraph, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court. "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital.

"Occupied bed days" shall be computed separately for each long-term care facility operated or maintained by a long-term care provider, and means the sum for all beds of the number of days during the month on which each bed was occupied by a resident, other than a resident for whom Medicare Part A is the primary payer. <u>For a resident whose care is covered by the Medicare Medicaid Alignment initiative demonstration, Medicare Part A is considered the primary payer.</u>

(Source: P.A. 96-339, eff. 7-1-10; 96-1530, eff. 2-16-11; 97-38, eff. 6-28-11; 97-227, eff. 1-1-12; 97-813, eff.

7-13-12.)

(305 ILCS 5/5C-1) (from Ch. 23, par. 5C-1)

Sec. 5C-1. Definitions. As used in this Article, unless the context requires otherwise:

"Fund" means the Care Provider Fund for Persons with a Developmental Disability.

"Developmentally disabled care facility" means an intermediate care facility for the intellectually disabled within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.

"Developmentally disabled care provider" means a person conducting, operating, or maintaining a developmentally disabled care facility. For this purpose, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian or other representative appointed by order of any court.

"Adjusted gross developmentally disabled care revenue" shall be computed separately for each developmentally disabled care facility conducted, operated, or maintained by a developmentally disabled care provider, and means the developmentally disabled care provider's total revenue for

inpatient residential services less contractual allowances and discounts on patients' accounts, but does not include non-patient revenue from sources such as contributions, donations or bequests, investments, day training services, television and telephone service, and rental of facility space.

"Long-term care facility for persons under 22 years of age serving clinically complex residents" means a facility licensed by the Department of Public Health as a long-term care facility for persons under 22 meeting the qualifications of Section 5-5.4h of this Code.

(Source: P.A. 97-227, eff. 1-1-12; 98-463, eff. 8-16-13.)

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

Sec. 5C-2. Assessment; no local authorization to tax.

(a) For the privilege of engaging in the occupation of developmentally disabled care provider, an assessment is imposed upon each developmentally disabled care provider in an amount equal to 6%, or the maximum allowed under federal regulation, whichever is less, of its adjusted gross developmentally disabled care revenue for the prior State fiscal year. Notwithstanding any provision of any other Act to the contrary, this assessment shall be construed as a tax, but may not be added to the charges of an individual's nursing home care that is paid for in whole, or in part, by a federal, State, or combined federal-state medical care program, except those individuals receiving Medicare Part B benefits solely.

(b) Nothing in this amendatory Act of 1995 shall be construed to authorize any home rule unit or other unit of local government to license for revenue or impose a tax or assessment upon a developmentally disabled care provider or the occupation of developmentally disabled care provider, or a tax or assessment measured by the income or earnings of a developmentally disabled care provider.

(c) Effective July 1, 2013, for the privilege of engaging in the occupation of long-term care facility for persons under 22 years of age serving clinically complex residents provider, an assessment is imposed upon each long-term care facility for persons under 22 years of age serving clinically complex residents provider in the same amount and upon the same conditions and requirements as imposed in Article V-B of this Code and a license fee is imposed in the same amount and upon the same conditions and requirements as imposed in Article V-E of this Code. Notwithstanding any provision of any other Act to the contrary, the assessment and license fee imposed by this subsection (c) shall be construed as a tax, but may not be added to the charges of an individual's nursing home care that is paid for in whole, or in part, by a federal, State, or combined federal-State medical care program, except for those individuals receiving Medicare Part B benefits solely.

(Source: P.A. 95-707, eff. 1-11-08.)

(305 ILCS 5/5C-7) (from Ch. 23, par. 5C-7)

Sec. 5C-7. Care Provider Fund for Persons with a Developmental Disability.

(a) There is created in the State Treasury the Care Provider Fund for Persons with a Developmental Disability. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any moneys appropriated to the Medicaid program by the General Assembly.

(b) The Fund is created for the purpose of receiving and disbursing assessment moneys in accordance with this Article. Disbursements from the Fund shall be made only as follows:

(1) For payments to intermediate care facilities for the developmentally disabled under Title XIX of the Social Security Act and Article V of this Code.

(2) For the reimbursement of moneys collected by the Illinois Department through error or mistake, and to make required payments under Section 5-4.28(a)(1) of this Code if there are no moneys available for such payments in the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund.

(3) For payment of administrative expenses incurred by the Department of Human Services or its agent or the Illinois Department or its agent in performing the activities authorized by this Article.

(4) For payments of any amounts which are reimbursable to the federal government for payments from this Fund which are required to be paid by State warrant.

(5) For making transfers to the General Obligation Bond Retirement and Interest Fund as those transfers are authorized in the proceedings authorizing debt under the Short Term Borrowing Act, but transfers made under this paragraph (5) shall not exceed the principal amount of debt issued in anticipation of the receipt by the State of moneys to be deposited into the Fund.

(6) For making refunds as required under Section 5C-10 of this Article.

Disbursements from the Fund, other than transfers to the General Obligation Bond Retirement and Interest Fund, shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Illinois Department.

(c) The Fund shall consist of the following:

(1) All moneys collected or received by the Illinois Department from the developmentally disabled care provider assessment imposed by this Article.

(2) All federal matching funds received by the Illinois Department as a result of expenditures made by the Illinois Department that are attributable to moneys deposited in the Fund.

(3) Any interest or penalty levied in conjunction with the administration of this Article.

(4) Any balance in the Medicaid Developmentally Disabled Care Provider Participation Fee Trust Fund in the

State Treasury. The balance shall be transferred to the Fund upon certification by the Illinois Department to the State Comptroller that all of the disbursements required by Section 5-4.21(b) of this Code have been made.

(5) All other moneys received for the Fund from any other source, including interest earned thereon.

(Source: P.A. 98-463, eff. 8-16-13.)

(305 ILCS 5/5C-10 new)

Sec. 5C-10. Adjustments. For long-term care facilities for persons under 22 years of age serving clinically complex residents previously classified as developmentally disabled care facilities under this Article, the Department shall refund any amounts paid under this Article in State fiscal year 2014 by the end of State fiscal year 2015 with at least half the refund amount being made prior to December 31, 2014. The amounts refunded shall be based on amounts paid by the facilities to the Department as the assessment under subsection (a) of Section 5C-2 less any assessment and license fee due for State fiscal year 2014.

(305 ILCS 5/Art. V-G heading new)

ARTICLE V-G. SUPPORTIVE LIVING FACILITY FUNDING.

(305 ILCS 5/5G-5 new)

Sec. 5G-5. Definitions. As used in this Article, unless the

context requires otherwise:

"Care days" shall be computed separately for each supportive living facility, and means the sum for all apartment units, the number of days during the month which each apartment unit was occupied by a resident.

"Department" means the Department of Healthcare and Family Services.

"Fund" means the Supportive Living Facility Fund.

"Supportive living facility" means an enrolled supportive living site as described under Section 5-5.01a of this Code that meets the participation requirements under Section 146.215 of Title 89 of the Illinois Administrative Code.

(305 ILCS 5/5G-10 new)

Sec. 5G-10. Assessment.

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

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

or earnings or care days of a supportive living facility.

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

(305 ILCS 5/5G-15 new)

Sec. 5G-15. Payment of assessment; penalty.

(a) The assessment imposed by Section 5G-10 shall be due and payable in monthly installments on the last State business day of the month for care days reported for the preceding third month prior to the month in which the assessment is payable and due. A facility that has delayed payment due to the State's failure to reimburse for services rendered may request an extension on the due date for payment pursuant to subsection (c) and shall pay the assessment within 30 days of reimbursement by the Department.

(b) The Department shall provide for an electronic submission process for each supportive living facility to report at a minimum the number of care days of the supportive

living facility for the reporting period and other reasonable information the Department requires for the administration of its responsibilities under this Code. The Department shall prepare an assessment bill stating the amount due and payable each month and submit it to each supportive living facility via an electronic process. To the extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of supportive living facilities.

(c) The Department is authorized to establish delayed payment schedules for supportive living facilities that are unable to make assessment payments when due under this Section due to financial difficulties, as determined by the Department. The Department may not deny a request for delay of payment of the assessment imposed under this Article if the supportive living facility has not been paid for services provided during the month in which the assessment is levied.

(d) If a supportive living facility fails to pay the full amount of an assessment payment when due (including any extensions granted under subsection (c)), there shall, unless waived by the Department for reasonable cause, be added to the assessment imposed by Section 5G-10 a penalty assessment equal to the lesser of (i) 1% of the amount of the assessment payment not paid on or before the due date plus 1% of the portion thereof remaining unpaid on the last day of each month thereafter or (ii) 100% of the assessment payment amount not

paid on or before the due date. For purposes of this subsection, payments will be credited first to unpaid assessment payment amounts (rather than to penalty or interest), beginning with the most delinquent assessment payments. Payment cycles of longer than 30 days shall be one factor the Director takes into account in granting a waiver under this Section.

(e) No installment of the assessment imposed by Section 5G-10 shall be due and payable until after the Department notifies the supportive living facilities, in writing, that the payment methodologies to supportive living facilities required under Section 5-5.01a of this Code have been approved by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. Upon notification to the Department of approval of the payment methodologies required under Section 5-5.01a of this Code and the waivers granted under 42 CFR 433.68, all installments otherwise due under this Section prior to the date of notification shall be due and payable to the Department upon written direction from the Department within 90 days after issuance by the Comptroller of the payments required under Section 5-5.01a of this Code.

(305 ILCS 5/5G-20 new)

Sec. 5G-20. Reporting; penalty; maintenance of records.

(a) Every supportive living facility subject to assessment under this Article shall report the number care days of the supportive living facility for the reporting period on or before the last business day of the month following the reporting period. Each supportive living facility shall ensure that an accurate e-mail address is on file with the Department in order for the Department to prepare and send an electronic bill to the supportive living facility.

(b) If a supportive living facility fails to file its monthly report with the Department when due, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due.

(c) Every supportive living facility subject to assessment under this Article shall keep records and books that will permit the determination of care days on a calendar year basis. All such books and records shall be kept in the English language and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

(d) Notwithstanding any other provision of this Article, a facility that commences operating or maintaining a supportive living facility that was under a prior ownership and remained enrolled as a Medicaid facility by the Department shall notify

the Department of the change in ownership and shall be responsible to immediately pay any prior amounts owed by the facility.

(e) The Department shall develop a procedure for sharing with a potential buyer of a facility information regarding outstanding assessments and penalties owed by that facility.

(305 ILCS 5/5G-25 new)

Sec. 5G-25. Disposition of proceeds. The Department shall pay all moneys received from supportive living facilities under this Article into the Supportive Living Facility Fund. Upon certification by the Department to the State Comptroller of its intent to withhold from a facility under Section 5G-30(b), the State Comptroller shall draw a warrant on the treasury or other fund held by the State Treasurer, as appropriate. The warrant shall state the amount for which the facility is entitled to a warrant, the amount of the deduction, and the reason therefor and shall direct the State Treasurer to pay the balance to the facility, all in accordance with Section 10.05 of the State Comptroller Act. The warrant also shall direct the State Treasurer to transfer the amount of the deduction so ordered from the treasury or other fund into the Supportive Living Facility Fund.

(305 ILCS 5/5G-30 new)

Sec. 5G-30. Administration; enforcement provisions.

(a) The Department shall administer and enforce this Article and collect the assessments and penalty assessments imposed under this Article using procedures employed in its administration of this Code generally and as follows:

(1) The Department may initiate either administrative or judicial proceedings, or both, to enforce provisions of this Article. Administrative enforcement proceedings initiated hereunder shall be governed by the Department's administrative rules. Judicial enforcement proceedings initiated hereunder shall be governed by the rules of procedure applicable in the courts of this State.

(2) No proceedings for collection, refund, credit, or other adjustment of an assessment amount shall be issued more than 3 years after the due date of the assessment, except in the case of an extended period agreed to in writing by the Department and the supportive living facility before the expiration of this limitation period.

(3) Any unpaid assessment under this Article shall become a lien upon the assets of the supportive living facility upon which it was assessed. If any supportive living facility, outside the usual course of its business, sells or transfers the major part of any one or more of (A) the real property and improvements, (B) the machinery and equipment, or (C) the furniture or fixtures, of any supportive living facility that is subject to the provisions of this Article, the seller or transferor shall

pay the Department the amount of any assessment, assessment penalty, and interest (if any) due from it under this Article up to the date of the sale or transfer. If the seller or transferor fails to pay any assessment, assessment penalty, and interest (if any) due, the purchaser or transferee of such asset shall be liable for the amount of the assessment, penalty, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee. The purchaser or transferee shall continue to be liable until the purchaser or transferee pays the full amount of the assessment, penalty, and interest (if any) up to the amount of the reasonable value of the property acquired by the purchaser or transferee or until the purchaser or transferee receives from the Department a certificate showing that such assessment, penalty, and interest have been paid or a certificate from the Department showing that no assessment, penalty, or interest is due from the seller or transferor under this Article.

(b) In addition to any other remedy provided for and without sending a notice of assessment liability, the Department may collect an unpaid assessment by withholding, as payment of the assessment, reimbursements or other amounts otherwise payable by the Department to the supportive living facility.

(305 ILCS 5/5G-35 new)

Sec. 5G-35. Supportive Living Facility Fund.

(a) There is created in the State treasury the Supportive Living Facility Fund. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any moneys appropriated to the Medicaid program by the General Assembly.

(b) The Fund is created for the purpose of receiving and disbursing moneys in accordance with this Article. Disbursements from the Fund, other than transfers authorized under paragraphs (5) and (6) of this subsection, shall be by warrants drawn by the State Comptroller upon receipt of vouchers duly executed and certified by the Department. Disbursements from the Fund shall be made only as follows:

(1) For making payments to supportive living facilities as required under this Code, under the Children's Health Insurance Program Act, under the Covering ALL KIDS Health Insurance Act, and under the Long Term Acute Care Hospital Quality Improvement Transfer Program Act.

(2) For the reimbursement of moneys collected by the Department from supportive living facilities through error or mistake in performing the activities authorized under this Code.

(3) For payment of administrative expenses incurred by the Department or its agent in performing administrative

oversight activities for the supportive living program or review of new supportive living facility applications.

(4) For payments of any amounts which are reimbursable to the federal government for payments from this Fund which are required to be paid by State warrant.

(5) For making transfers, as those transfers are authorized in the proceedings authorizing debt under the Short Term Borrowing Act, but transfers made under this paragraph (5) shall not exceed the principal amount of debt issued in anticipation of the receipt by the State of moneys to be deposited into the Fund.

(6) For making transfers to any other fund in the State treasury, but transfers made under this paragraph (6) shall not exceed the amount transferred previously from that other fund into the Supportive Living Facility Fund plus any interest that would have been earned by that fund on the money that had been transferred.

(c) The Fund shall consist of the following:

(1) All moneys collected or received by the Department from the supportive living facility assessment imposed by this Article.

(2) All moneys collected or received by the Department from the supportive living facility certification fee imposed by this Article.

(3) All federal matching funds received by the Department as a result of expenditures made by the

Department that are attributable to moneys deposited in the Fund.

(4) Any interest or penalty levied in conjunction with the administration of this Article.

(5) Moneys transferred from another fund in the State treasury.

(6) All other moneys received for the Fund from any other source, including interest earned thereon.

(305 ILCS 5/5G-40 new)

Sec. 5G-40. Certification fee.

(a) The Department shall collect an annual certification fee of $100 per each operational or approved supportive living facility for the purposes of funding the administrative process of reviewing new supportive living facility applications and administrative oversight of the health care services delivered by supportive living facilities.

(b) The certification fee shall be deposited into the Supportive Living Facility Fund. The Department shall maintain a separate accounting of amounts collected under this Section.

(305 ILCS 5/5G-45 new)

Sec. 5G-45. Applicability.

(a) The Department must submit any necessary documentation to the Centers for Medicare and Medicaid Services which allows for an effective date of July 1, 2014 for the requirements of

this Article. The documents shall include any necessary documents that satisfy federal public notice requirements, Medicaid state plan amendments, and any Medicaid waiver amendments.

(b) The assessment imposed by Section 5G-10 shall cease to be imposed if the amount of matching federal funds under Title XIX of the Social Security Act is eliminated or significantly reduced on account of the assessment. Any remaining assessments shall be refunded to supportive living facilities in proportion to the amounts of the assessments paid by them.

(c) The certification fee imposed by Section 5G-40 shall cease to be imposed if the amount of matching federal funds under Title XIX of the Social Security Act is eliminated or significantly reduced on account of the certification fee.

Section 55-20. The Immunization Data Registry Act is amended by changing Section 20 as follows:

(410 ILCS 527/20)

Sec. 20. Confidentiality of information; release of information; statistics; panel on expanding access.

(a) Records maintained as part of the immunization data registry are confidential.

(b) The Department may release an individual's confidential information to the individual or to the individual's parent or guardian if the individual is less than

18 years of age.

(c) Subject to subsection (d) of this Section, the Department may release information in the immunization data registry concerning an individual to the following entities:

(1) The immunization data registry of another state.

(2) A health care provider or a health care provider's designee.

(3) A local health department.

(4) An elementary or secondary school that is attended by the individual.

(5) A licensed child care center in which the individual is enrolled.

(6) A licensed child-placing agency.

(7) A college or university that is attended by the individual.

(8) The Department of Healthcare and Family Services or a managed care entity contracted with the Department of Healthcare and Family Services to coordinate the provision of medical care to enrollees of the medical assistance program.

(d) Before immunization data may be released to an entity, the entity must enter into an agreement with the Department that provides that information that identifies a patient will not be released to any other person without the written consent of the patient.

(e) The Department may release summary statistics

regarding information in the immunization data registry if the summary statistics do not reveal the identity of an individual. (Source: P.A. 97-117, eff. 7-14-11.)

Article 60

Section 60-5. The Lead Poisoning Prevention Act is amended by adding Section 15.1 as follows:

(410 ILCS 45/15.1 new)

Sec. 15.1. Funding. Beginning July 1, 2014 and ending June 30, 2018, a hospital satisfying the definition, as of July 1, 2014, of Section 5-5e.1 of the Illinois Public Aid Code and located in DuPage County shall pay the sum of $2,000,000 annually in 4 equal quarterly installments to the human poison control center in existence as of July 1, 2014 and established under the authority of this Act.

Article 99

Section 99-1. Severability. If any clause, sentence, Section, exemption, provision, or part of this Act or the application thereof to any person or circumstance shall be adjudged to be unconstitutional or otherwise invalid, the remainder of this Act or its application to persons or circumstances other than those to which it is held invalid

shall not be affected thereby and to this end the provisions of this Act are declared to be severable.

Section 99-2. Any action required by this Act to occur prior to or on June 30, 2014 shall be completed within 30 days after the effective date of this Act.

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