Rep. Robyn Gabel

Filed: 4/5/2018

AMENDMENT TO HOUSE BILL 4347

AMENDMENT NO. _____. Amend House Bill 4347 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Public Aid Code is amended by changing Sections 5-5, 5-30, and 5-30.1 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. 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, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical 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.

On and after July 1, 2018, the Department of Healthcare and Family Services shall provide dental services to any adult who is otherwise eligible for assistance under the medical assistance program. As used in this paragraph, "dental services" means diagnostic, preventative, restorative, or corrective procedures, including procedures and services for the prevention and treatment of periodontal disease and dental caries disease, provided by an individual who is licensed to practice dentistry or dental surgery or who is under the supervision of a dentist in the practice of his or her profession.

On and after July 1, 2018, targeted dental services, as set forth in Exhibit D of the Consent Decree entered by the United States District Court for the Northern District of Illinois, Eastern Division, in the matter of Memisovski v. Maram, Case No. 92 C 1982, that are provided to adults under the medical assistance program shall be reimbursed at no less than the rates set forth in the "New Rate" column in Exhibit D of the Consent Decree for targeted dental services that are provided

to persons under the age of 18 under the medical assistance program.

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 and MRI 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.

(E) A screening MRI 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 and includes breast tomosynthesis. As used in this Section, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast. If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

On and after January 1, 2016, the Department shall ensure that all networks of care for adult clients of the Department

include access to at least one breast imaging Center of Imaging Excellence as certified by the American College of Radiology.

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 for mammography.

On and after January 1, 2017, providers participating in a breast cancer treatment quality improvement program approved by the Department shall be reimbursed for breast cancer treatment at a rate that is no lower than 95% of the Medicare program's rates for the data elements included in the breast cancer treatment quality program.

The Department shall convene an expert panel, including representatives of hospitals, free standing breast cancer treatment centers, breast cancer quality organizations, and doctors, including breast surgeons, reconstructive breast surgeons, oncologists, and primary care providers to establish quality standards for breast cancer treatment.

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. By January 1, 2016, the Department shall report to the General Assembly on the status of the provision set forth in this paragraph.

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 work with experts in breast cancer outreach and patient navigation to optimize these reminders and shall establish a methodology for evaluating their effectiveness and modifying the methodology based on the evaluation.

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. On or after July 1,

2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within metropolitan Chicago. 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.

The Department shall require all networks of care to develop a means either internally or by contract with experts in navigation and community outreach to navigate cancer patients to comprehensive care in a timely fashion. The Department shall require all networks of care to include access for patients diagnosed with cancer to at least one academic commission on cancer-accredited cancer program as an in-network covered benefit.

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 September 16, 1984 (the effective date of Public Act 83-1439), 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.

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), 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, by July 1, 2016, test the viability of the new system and implement any necessary operational or structural changes to its information technology platforms in

order to allow for the direct acceptance and payment of nursing home claims.

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after August 15, 2014 (the effective date of Public Act 98-963), establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act and MC/DD facilities licensed under the MC/DD 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 45 calendar days of receipt by the facility of required prescreening information, new admissions with associated admission documents shall be submitted through 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. Notwithstanding any provision of Section 5-5f to the contrary, the Department may, by rule, exempt certain replacement wheelchair parts from prior approval and, for wheelchairs, wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

The Department shall require, by rule, all providers of durable medical equipment to be accredited by an accreditation organization approved by the federal Centers for Medicare and Medicaid Services and recognized by the Department in order to bill the Department for providing durable medical equipment to

recipients. No later than 15 months after the effective date of the rule adopted pursuant to this paragraph, all providers must meet the accreditation requirement.

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.

Notwithstanding any other provision of this Code to the contrary, on or after July 1, 2015, all FDA approved forms of medication assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be covered under both fee for service and managed care medical assistance programs for persons who are otherwise eligible for medical assistance under this Article and shall not be subject to any (1) utilization control, other than those established under the American Society of Addiction Medicine patient placement criteria, (2) prior authorization mandate, or (3) lifetime restriction limit mandate.

On or after July 1, 2015, opioid antagonists prescribed for the treatment of an opioid overdose, including the medication

product, administration devices, and any pharmacy fees related to the dispensing and administration of the opioid antagonist, shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article. As used in this Section, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

Upon federal approval, the Department shall provide coverage and reimbursement for all drugs that are approved for marketing by the federal Food and Drug Administration and that are recommended by the federal Public Health Service or the United States Centers for Disease Control and Prevention for pre-exposure prophylaxis and related pre-exposure prophylaxis services, including, but not limited to, HIV and sexually transmitted infection screening, treatment for sexually transmitted infections, medical monitoring, assorted labs, and counseling to reduce the likelihood of HIV infection among individuals who are not infected with HIV but who are at high risk of HIV infection.

(Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for the effective date of P.A. 99-407); 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.

7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; revised 10-26-17.)

(305 ILCS 5/5-30)

Sec. 5-30. Care coordination.

(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii)

to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

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

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of January 25, 2011 (the effective date of Public Act 96-1501).

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program report, beginning April, 2012 until April, 2016, on the

progress and implementation of the care coordination program initiatives established by the provisions of Public Act 96-1501. The Department shall include in its April 2011 report a full analysis of federal laws or regulations regarding upper payment limitations to providers and the necessary revisions or adjustments in rate methodologies and payments to providers under this Code that would be necessary to implement coordinated care with full financial risk by a party other than the Department.

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

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

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

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

through other risk-based payment arrangements such as provider-based care coordination.

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

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

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

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

(f) A hospital that is located in a county of the State in which the Department mandates some or all of the beneficiaries of the Medical Assistance Program residing in the county to enroll in a Care Coordination Program, as set forth in Section 5-30 of this Code, shall not be eligible for any non-claims based payments not mandated by Article V-A of this Code for which it would otherwise be qualified to receive, unless the hospital is a Coordinated Care Participating Hospital no later

than 60 days after June 14, 2012 (the effective date of Public Act 97-689) or 60 days after the first mandatory enrollment of a beneficiary in a Coordinated Care program. For purposes of this subsection, "Coordinated Care Participating Hospital" means a hospital that meets one of the following criteria:

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

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

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

(g) No later than August 1, 2013, the Department shall issue a purchase of care solicitation for Accountable Care Entities (ACE) to serve any children and parents or caretaker relatives of children eligible for medical assistance under this Article. An ACE may be a single corporate structure or a

network of providers organized through contractual relationships with a single corporate entity. The solicitation shall require that:

(1) An ACE operating in Cook County be capable of serving at least 40,000 eligible individuals in that county; an ACE operating in Lake, Kane, DuPage, or Will Counties be capable of serving at least 20,000 eligible individuals in those counties and an ACE operating in other regions of the State be capable of serving at least 10,000 eligible individuals in the region in which it operates. During initial periods of mandatory enrollment, the Department shall require its enrollment services contractor to use a default assignment algorithm that ensures if possible an ACE reaches the minimum enrollment levels set forth in this paragraph.

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

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

(4) An ACE must be an integrated delivery system, including a network able to provide the full range of services needed by Medicaid beneficiaries and system capacity to securely pass clinical information across

participating entities and to aggregate and analyze that data in order to coordinate care.

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

(6) In the first 18 months of operation, unless the ACE selects a shorter period, an ACE shall be paid care coordination fees on a per member per month basis that are projected to be cost neutral to the State during the term of their payment and, subject to federal approval, be eligible to share in additional savings generated by their care coordination.

(7) In months 19 through 36 of operation, unless the ACE selects a shorter period, an ACE shall be paid on a pre-paid capitation basis for all medical assistance covered services, under contract terms similar to Managed Care Organizations (MCO), with the Department sharing the risk through either stop-loss insurance for extremely high cost individuals or corridors of shared risk based on the overall cost of the total enrollment in the ACE. The ACE shall be responsible for claims processing, encounter data submission, utilization control, and quality assurance.

(8) In the fourth and subsequent years of operation, an

ACE shall convert to a Managed Care Community Network (MCCN), as defined in this Article, or Health Maintenance Organization pursuant to the Illinois Insurance Code, accepting full-risk capitation payments.

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

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

Nothing in this subsection shall be construed to limit the Department's mandate to enroll 50% of its beneficiaries into

care coordination systems by January 1, 2015, using all available care coordination delivery systems, including Care Coordination Entities (CCE), MCCNs, or MCOs, nor be construed to affect the current CCEs, MCCNs, and MCOs selected to serve seniors and persons with disabilities prior to that date.

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

(h) Department contracts with MCOs and other entities reimbursed by risk based capitation shall have a minimum medical loss ratio of 85%, shall require the entity to establish an appeals and grievances process for consumers and providers, and shall require the entity to provide a quality assurance and utilization review program. Entities contracted with the Department to coordinate healthcare regardless of risk shall be measured utilizing the same quality metrics. The quality metrics may be population specific. Any contracted entity serving at least 5,000 seniors or people with disabilities or 15,000 individuals in other populations covered by the Medical Assistance Program that has been receiving full-risk capitation for a year shall be accredited by a national accreditation organization authorized by the Department within 2 years after the date it is eligible to become accredited. The requirements of this subsection shall apply to contracts with MCOs entered into or renewed or extended after June 1, 2013.

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

(i) Unless otherwise required by federal law, Medicaid Managed Care Entities and their respective business associates shall not disclose, directly or indirectly, including by sending a bill or explanation of benefits, information concerning the sensitive health services received by enrollees of the Medicaid Managed Care Entity to any person other than covered entities and business associates, which may receive, use, and further disclose such information solely for the purposes permitted under applicable federal and State laws and regulations if such use and further disclosure satisfies all applicable requirements of such laws and regulations. The Medicaid Managed Care Entity or its respective business associates may disclose information concerning the sensitive health services if the enrollee who received the sensitive health services requests the information from the Medicaid Managed Care Entity or its respective business associates and

authorized the sending of a bill or explanation of benefits. Communications including, but not limited to, statements of care received or appointment reminders either directly or indirectly to the enrollee from the health care provider, health care professional, and care coordinators, remain permissible. Medicaid Managed Care Entities or their respective business associates may communicate directly with their enrollees regarding care coordination activities for those enrollees.

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

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

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

Nothing in this subsection shall be construed to relieve a Medicaid Managed Care Entity or the Department of any duty to report incidents of sexually transmitted infections to the

Department of Public Health or to the local board of health in accordance with regulations adopted under a statute or ordinance or to report incidents of sexually transmitted infections as necessary to comply with the requirements under Section 5 of the Abused and Neglected Child Reporting Act or as otherwise required by State or federal law.

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

(j) Managed Care Entities (MCEs), including MCOs and all other care coordination organizations, shall develop and maintain a written language access policy that sets forth the standards, guidelines, and operational plan to ensure language appropriate services and that is consistent with the standard of meaningful access for populations with limited English proficiency. The language access policy shall describe how the MCEs will provide all of the following required services:

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

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

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

language assistance services.

(4) Data tracking that identifies the language need.

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

(k) The Department shall actively monitor the contractual relationship between Managed Care Organizations (MCOs) and any dental administrator contracted by an MCO to provide dental services. The Department shall adopt appropriate dental Healthcare Effectiveness Data and Information Set measures or other dental quality performance measures as part of its monitoring and shall include additional specific dental performance measurers in its Health Plan Comparison Tool and Illinois Medicaid Plan Report Card that is available on the Department's website for enrolled individuals.

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

(Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14; 99-106, eff. 1-1-16; 99-181, eff. 7-29-15; 99-566, eff. 1-1-17; 99-642, eff. 7-28-16.)

(305 ILCS 5/5-30.1)

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 and transparency.

(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, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3.

(2) Each MCO shall confirm its receipt of information

submitted specific to physician or dentist additions or physician or dentist deletions from the MCO's provider network within 3 days after receiving all required information from contracted physicians or dentists, and electronic physician and dental directories must be updated consistent with current rules as published by the Centers for Medicare and Medicaid Services or its successor agency.

(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.

(g-5) Recognizing that the rapid transformation of the Illinois Medicaid program may have unintended operational challenges for both payers and providers:

(1) in no instance shall a medically necessary covered service rendered in good faith, based upon eligibility

information documented by the provider, be denied coverage or diminished in payment amount if the eligibility or coverage information available at the time the service was rendered is later found to be inaccurate; and

(2) the Department shall, by December 31, 2016, adopt rules establishing policies that shall be included in the Medicaid managed care policy and procedures manual addressing payment resolutions in situations in which a provider renders services based upon information obtained after verifying a patient's eligibility and coverage plan through either the Department's current enrollment system or a system operated by the coverage plan identified by the patient presenting for services:

(A) such medically necessary covered services shall be considered rendered in good faith;

(B) such policies and procedures shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

(3) The rules on payment resolutions shall include, but

not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

(4) The rules shall be applicable for both MCO coverage and fee-for-service coverage.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

(2) The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(3) The metrics shall be developed in consultation with industry representatives of the Medicaid managed care

health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

(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 June 16, 2014 (the effective date of Public Act 98-651).

(Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16; 100-201, eff. 8-18-17; 100-580, eff. 3-12-18.)

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