HB5883

LRB10021964KTG39977b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB5883

by Rep. Gregory Harris

SYNOPSIS AS INTRODUCED:

305 ILCS 5/12-4.42

Amends the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to contract with a vendor to perform the coordination of benefits for Medicaid fee-for-service and managed care enrollees (rather than contract with a vendor to support the Department in coordinating benefits for Medicaid enrollees). Provides that the contract with the vendor shall include, but not be limited to, a review of the following populations: persons eligible for both Medicare and Medicaid benefits (dual-eligible clients); persons enrolled in the fee-for-service medical assistance program; persons enrolled in the managed care medical assistance program; and persons eligible for benefits provided under the Children's Health Insurance Program Act. Provides that if the Department does not issue a comprehensive procurement, including both the identification of other insurance and the recovery of funds for the populations listed, and contracts with a vendor for both pieces within 3 months after the effective date of the amendatory Act, the Department's Inspector General shall procure for the identification and recovery of other insurance.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Section 12-4.42 as follows:

(305 ILCS 5/12-4.42)

Sec. 12-4.42. Medicaid Revenue Maximization.

(a) Purpose. The General Assembly finds that there is a need to make changes to the administration of services provided by State and local governments in order to maximize federal financial participation.

(b) Definitions. As used in this Section:

"Community Medicaid mental health services" means all mental health services outlined in Part 132 of Title 59 of the Illinois Administrative Code that are funded through DHS, eligible for federal financial participation, and provided by a community-based provider.

"Community-based provider" means an entity enrolled as a provider pursuant to Sections 140.11 and 140.12 of Title 89 of the Illinois Administrative Code and certified to provide community Medicaid mental health services in accordance with Part 132 of Title 59 of the Illinois Administrative Code.

"DCFS" means the Department of Children and Family

Services.

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

"Care facility for persons with a developmental disability" means an intermediate care facility for persons with an intellectual disability 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.

"Care provider for persons with a developmental disability" means a person conducting, operating, or maintaining a care facility for persons with a developmental disability. For purposes of this definition, "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.

"DHS" means the Illinois Department of Human Services.

"Hospital" means an institution, place, building, or agency located in this State that is licensed as a general acute hospital by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

"Long term care facility" means (i) a skilled nursing or intermediate long term care 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, 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 solely as an intermediate care facility for the intellectually disabled 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 definition, "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.

"State-operated facility for persons with a developmental disability" means an intermediate care facility for persons with an intellectual disability within the meaning of Title XIX

of the Social Security Act operated by the State.

(c) Administration and deposit of Revenues. The Department shall coordinate the implementation of changes required by Public Act 96-1405 amongst the various State and local government bodies that administer programs referred to in this Section.

Revenues generated by program changes mandated by any provision in this Section, less reasonable administrative costs associated with the implementation of these program changes, which would otherwise be deposited into the General Revenue Fund shall be deposited into the Healthcare Provider Relief Fund.

The Department shall issue a report to the General Assembly detailing the implementation progress of Public Act 96-1405 as a part of the Department's Medical Programs annual report for fiscal years 2010 and 2011.

(d) Acceleration of payment vouchers. To the extent practicable and permissible under federal law, the Department shall create all vouchers for long term care facilities and facilities for persons with a developmental disability for dates of service in the month in which the enhanced federal medical assistance percentage (FMAP) originally set forth in the American Recovery and Reinvestment Act (ARRA) expires and for dates of service in the month prior to that month and shall, no later than the 15th of the month in which the enhanced FMAP expires, submit these vouchers to the Comptroller

for payment.

The Department of Human Services shall create the necessary documentation for State-operated facilities for persons with a developmental disability so that the necessary data for all dates of service before the expiration of the enhanced FMAP originally set forth in the ARRA can be adjudicated by the Department no later than the 15th of the month in which the enhanced FMAP expires.

(e) Billing of DHS community Medicaid mental health services. No later than July 1, 2011, community Medicaid mental health services provided by a community-based provider must be billed directly to the Department.

(f) DCFS Medicaid services. The Department shall work with DCFS to identify existing programs, pending qualifying services, that can be converted in an economically feasible manner to Medicaid in order to secure federal financial revenue.

(g) Third Party Liability ~~recoveries~~. The Department shall contract with a vendor to perform the coordination of ~~support the Department in coordinating~~ benefits for Medicaid fee-for-service and managed care enrollees. The scope of work shall include, but not be limited to, ~~at a minimum,~~ the identification of other insurance for Medicaid enrollees and the recovery of funds paid by the Department when another payer was liable. The contract with the vendor shall include, but not be limited to, a review of the following populations: persons

eligible for both Medicare and Medicaid benefits (dual-eligible clients); persons enrolled in the fee-for-service medical assistance program; persons enrolled in the managed care medical assistance program; and persons eligible for benefits provided under the Children's Health Insurance Program Act. If the Department does not issue a comprehensive procurement, including both the identification of other insurance and the recovery of funds for the populations listed in this subsection, and contracts with a vendor for both pieces within 3 months after the effective date of this amendatory Act of the 100th General Assembly, the Department's Inspector General shall procure for the identification and recovery of other insurance. The vendor may be paid a percentage of actual cash recovered when practical and subject to federal law.

(h) Public health departments. The Department shall identify unreimbursed costs for persons covered by Medicaid who are served by the Chicago Department of Public Health.

The Department shall assist the Chicago Department of Public Health in determining total unreimbursed costs associated with the provision of healthcare services to Medicaid enrollees.

The Department shall determine and draw the maximum allowable federal matching dollars associated with the cost of Chicago Department of Public Health services provided to Medicaid enrollees.

(i) Acceleration of hospital-based payments. The Department shall, by the 10th day of the month in which the enhanced FMAP originally set forth in the ARRA expires, create vouchers for all State fiscal year 2011 hospital payments exempt from the prompt payment requirements of the ARRA. The Department shall submit these vouchers to the Comptroller for payment.

(Source: P.A. 99-143, eff. 7-27-15; 100-201, eff. 8-18-17.)