



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

SB2429

Introduced 1/30/2018, by Sen. Omar Aquino

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5
305 ILCS 5/5-30

from Ch. 23, par. 5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that the Department of Healthcare and Family Services shall provide dental services to an adult who is otherwise eligible for assistance under the medical assistance program. Provides that targeted dental services, as set forth in a specified exhibit in a federal consent decree, that are provided to adults under the medical assistance program shall be reimbursed at the rates set forth in a specified column in the exhibit for targeted dental services that are provided to persons under the age of 18 under the medical assistance program. Requires the Department to actively monitor the contractual relationship between Managed Care Organizations (MCOs) and a dental administrator contracted by an MCO to provide dental services. Contains provisions concerning the Department's adoption of appropriate data and measures; the inclusion of certain dental performance measures in the Department's Health Plan Comparison Tool and Illinois Medicaid Plan Report Card; and the collection of information about the types of contracted, broad-based care coordination occurring between a MCO and any dental administrator. Prohibits a health plan from attempting to limit the right of medical assistance recipients to obtain dental services from a qualified Medicaid provider. Prohibits the Department from adopting a rule or entering into a contract that prohibits a licensed dentist or dental hygienist from receiving reimbursement under the medical assistance program for a dental encounter. Effective immediately.

LRB100 16511 KTG 31643 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

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

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Sections 5-5 and 5-30 as follows:

6 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

1 procedures provided by or under the supervision of a dentist in
2 the practice of his or her profession; (11) physical therapy
3 and related services; (12) prescribed drugs, dentures, and
4 prosthetic devices; and eyeglasses prescribed by a physician
5 skilled in the diseases of the eye, or by an optometrist,
6 whichever the person may select; (13) other diagnostic,
7 screening, preventive, and rehabilitative services, including
8 to ensure that the individual's need for intervention or
9 treatment of mental disorders or substance use disorders or
10 co-occurring mental health and substance use disorders is
11 determined using a uniform screening, assessment, and
12 evaluation process inclusive of criteria, for children and
13 adults; for purposes of this item (13), a uniform screening,
14 assessment, and evaluation process refers to a process that
15 includes an appropriate evaluation and, as warranted, a
16 referral; "uniform" does not mean the use of a singular
17 instrument, tool, or process that all must utilize; (14)
18 transportation and such other expenses as may be necessary;
19 (15) medical treatment of sexual assault survivors, as defined
20 in Section 1a of the Sexual Assault Survivors Emergency
21 Treatment Act, for injuries sustained as a result of the sexual
22 assault, including examinations and laboratory tests to
23 discover evidence which may be used in criminal proceedings
24 arising from the sexual assault; (16) the diagnosis and
25 treatment of sickle cell anemia; and (17) any other medical
26 care, and any other type of remedial care recognized under the

1 laws of this State. The term "any other type of remedial care"
2 shall include nursing care and nursing home service for persons
3 who rely on treatment by spiritual means alone through prayer
4 for healing.

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

12 Notwithstanding any other provision of this Code,
13 reproductive health care that is otherwise legal in Illinois
14 shall be covered under the medical assistance program for
15 persons who are otherwise eligible for medical assistance under
16 this Article.

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

24 Upon receipt of federal approval of an amendment to the
25 Illinois Title XIX State Plan for this purpose, the Department
26 shall authorize the Chicago Public Schools (CPS) to procure a

1 vendor or vendors to manufacture eyeglasses for individuals
2 enrolled in a school within the CPS system. CPS shall ensure
3 that its vendor or vendors are enrolled as providers in the
4 medical assistance program and in any capitated Medicaid
5 managed care entity (MCE) serving individuals enrolled in a
6 school within the CPS system. Under any contract procured under
7 this provision, the vendor or vendors must serve only
8 individuals enrolled in a school within the CPS system. Claims
9 for services provided by CPS's vendor or vendors to recipients
10 of benefits in the medical assistance program under this Code,
11 the Children's Health Insurance Program, or the Covering ALL
12 KIDS Health Insurance Program shall be submitted to the
13 Department or the MCE in which the individual is enrolled for
14 payment and shall be reimbursed at the Department's or the
15 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

12 On and after July 1, 2018, targeted dental services, as set
13 forth in Exhibit D of the Consent Decree entered by the United
14 States District Court for the Northern District of Illinois,
15 Eastern Division, in the matter of Memisovski v. Maram, Case
16 No. 92 C 1982, that are provided to adults under the medical
17 assistance program shall be reimbursed at the rates set forth
18 in the "New Rate" column in Exhibit D of the Consent Decree for
19 targeted dental services that are provided to persons under the
20 age of 18 under the medical assistance program.

21 Notwithstanding any other provision of this Code and
22 subject to federal approval, the Department may adopt rules to
23 allow a dentist who is volunteering his or her service at no
24 cost to render dental services through an enrolled
25 not-for-profit health clinic without the dentist personally
26 enrolling as a participating provider in the medical assistance

1 program. A not-for-profit health clinic shall include a public
2 health clinic or Federally Qualified Health Center or other
3 enrolled provider, as determined by the Department, through
4 which dental services covered under this Section are performed.
5 The Department shall establish a process for payment of claims
6 for reimbursement for covered dental services rendered under
7 this provision.

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

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

18 The Illinois Department shall authorize the provision of,
19 and shall authorize payment for, screening by low-dose
20 mammography for the presence of occult breast cancer for women
21 35 years of age or older who are eligible for medical
22 assistance under this Article, as follows:

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

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

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

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

11 (E) A screening MRI when medically necessary, as
12 determined by a physician licensed to practice medicine in
13 all of its branches.

14 All screenings shall include a physical breast exam,
15 instruction on self-examination and information regarding the
16 frequency of self-examination and its value as a preventative
17 tool. For purposes of this Section, "low-dose mammography"
18 means the x-ray examination of the breast using equipment
19 dedicated specifically for mammography, including the x-ray
20 tube, filter, compression device, and image receptor, with an
21 average radiation exposure delivery of less than one rad per
22 breast for 2 views of an average size breast. The term also
23 includes digital mammography and includes breast
24 tomosynthesis. As used in this Section, the term "breast
25 tomosynthesis" means a radiologic procedure that involves the
26 acquisition of projection images over the stationary breast to

1 produce cross-sectional digital three-dimensional images of
2 the breast. If, at any time, the Secretary of the United States
3 Department of Health and Human Services, or its successor
4 agency, promulgates rules or regulations to be published in the
5 Federal Register or publishes a comment in the Federal Register
6 or issues an opinion, guidance, or other action that would
7 require the State, pursuant to any provision of the Patient
8 Protection and Affordable Care Act (Public Law 111-148),
9 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
10 successor provision, to defray the cost of any coverage for
11 breast tomosynthesis outlined in this paragraph, then the
12 requirement that an insurer cover breast tomosynthesis is
13 inoperative other than any such coverage authorized under
14 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
15 the State shall not assume any obligation for the cost of
16 coverage for breast tomosynthesis set forth in this paragraph.

17 On and after January 1, 2016, the Department shall ensure
18 that all networks of care for adult clients of the Department
19 include access to at least one breast imaging Center of Imaging
20 Excellence as certified by the American College of Radiology.

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

26 The Department shall convene an expert panel including

1 representatives of hospitals, free-standing mammography
2 facilities, and doctors, including radiologists, to establish
3 quality standards for mammography.

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

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

16 Subject to federal approval, the Department shall
17 establish a rate methodology for mammography at federally
18 qualified health centers and other encounter-rate clinics.
19 These clinics or centers may also collaborate with other
20 hospital-based mammography facilities. By January 1, 2016, the
21 Department shall report to the General Assembly on the status
22 of the provision set forth in this paragraph.

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

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

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

12 The Department shall devise a means of case-managing or
13 patient navigation for beneficiaries diagnosed with breast
14 cancer. This program shall initially operate as a pilot program
15 in areas of the State with the highest incidence of mortality
16 related to breast cancer. At least one pilot program site shall
17 be in the metropolitan Chicago area and at least one site shall
18 be outside the metropolitan Chicago area. On or after July 1,
19 2016, the pilot program shall be expanded to include one site
20 in western Illinois, one site in southern Illinois, one site in
21 central Illinois, and 4 sites within metropolitan Chicago. An
22 evaluation of the pilot program shall be carried out measuring
23 health outcomes and cost of care for those served by the pilot
24 program compared to similarly situated patients who are not
25 served by the pilot program.

26 The Department shall require all networks of care to

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

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

20 All medical providers providing medical assistance to
21 pregnant women under this Code shall receive information from
22 the Department on the availability of services under the Drug
23 Free Families with a Future or any comparable program providing
24 case management services for addicted women, including
25 information on appropriate referrals for other social services
26 that may be needed by addicted women in addition to treatment

1 for addiction.

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

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

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

22 The Illinois Department may develop and contract with
23 Partnerships of medical providers to arrange medical services
24 for persons eligible under Section 5-2 of this Code.
25 Implementation of this Section may be by demonstration projects
26 in certain geographic areas. The Partnership shall be

1 represented by a sponsor organization. The Department, by rule,
2 shall develop qualifications for sponsors of Partnerships.
3 Nothing in this Section shall be construed to require that the
4 sponsor organization be a medical organization.

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

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

20 (2) The Department may elect to consider and negotiate
21 financial incentives to encourage the development of
22 Partnerships and the efficient delivery of medical care.

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

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

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

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

22 The Illinois Department shall require health care
23 providers to maintain records that document the medical care
24 and services provided to recipients of Medical Assistance under
25 this Article. Such records must be retained for a period of not
26 less than 6 years from the date of service or as provided by

1 applicable State law, whichever period is longer, except that
2 if an audit is initiated within the required retention period
3 then the records must be retained until the audit is completed
4 and every exception is resolved. The Illinois Department shall
5 require health care providers to make available, when
6 authorized by the patient, in writing, the medical records in a
7 timely fashion to other health care providers who are treating
8 or serving persons eligible for Medical Assistance under this
9 Article. All dispensers of medical services shall be required
10 to maintain and retain business and professional records
11 sufficient to fully and accurately document the nature, scope,
12 details and receipt of the health care provided to persons
13 eligible for medical assistance under this Code, in accordance
14 with regulations promulgated by the Illinois Department. The
15 rules and regulations shall require that proof of the receipt
16 of prescription drugs, dentures, prosthetic devices and
17 eyeglasses by eligible persons under this Section accompany
18 each claim for reimbursement submitted by the dispenser of such
19 medical services. No such claims for reimbursement shall be
20 approved for payment by the Illinois Department without such
21 proof of receipt, unless the Illinois Department shall have put
22 into effect and shall be operating a system of post-payment
23 audit and review which shall, on a sampling basis, be deemed
24 adequate by the Illinois Department to assure that such drugs,
25 dentures, prosthetic devices and eyeglasses for which payment
26 is being made are actually being received by eligible

1 recipients. Within 90 days after September 16, 1984 (the
2 effective date of Public Act 83-1439), the Illinois Department
3 shall establish a current list of acquisition costs for all
4 prosthetic devices and any other items recognized as medical
5 equipment and supplies reimbursable under this Article and
6 shall update such list on a quarterly basis, except that the
7 acquisition costs of all prescription drugs shall be updated no
8 less frequently than every 30 days as required by Section
9 5-5.12.

10 Notwithstanding any other law to the contrary, the Illinois
11 Department shall, within 365 days after July 22, 2013 (the
12 effective date of Public Act 98-104), establish procedures to
13 permit skilled care facilities licensed under the Nursing Home
14 Care Act to submit monthly billing claims for reimbursement
15 purposes. Following development of these procedures, the
16 Department shall, by July 1, 2016, test the viability of the
17 new system and implement any necessary operational or
18 structural changes to its information technology platforms in
19 order to allow for the direct acceptance and payment of nursing
20 home claims.

21 Notwithstanding any other law to the contrary, the Illinois
22 Department shall, within 365 days after August 15, 2014 (the
23 effective date of Public Act 98-963), establish procedures to
24 permit ID/DD facilities licensed under the ID/DD Community Care
25 Act and MC/DD facilities licensed under the MC/DD Act to submit
26 monthly billing claims for reimbursement purposes. Following

1 development of these procedures, the Department shall have an
2 additional 365 days to test the viability of the new system and
3 to ensure that any necessary operational or structural changes
4 to its information technology platforms are implemented.

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

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

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

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

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

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

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

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

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

11 (1) In the case of a provider whose enrollment is in
12 process by the Illinois Department, the 180-day period
13 shall not begin until the date on the written notice from
14 the Illinois Department that the provider enrollment is
15 complete.

16 (2) In the case of errors attributable to the Illinois
17 Department or any of its claims processing intermediaries
18 which result in an inability to receive, process, or
19 adjudicate a claim, the 180-day period shall not begin
20 until the provider has been notified of the error.

21 (3) In the case of a provider for whom the Illinois
22 Department initiates the monthly billing process.

23 (4) In the case of a provider operated by a unit of
24 local government with a population exceeding 3,000,000
25 when local government funds finance federal participation
26 for claims payments.

1 For claims for services rendered during a period for which
2 a recipient received retroactive eligibility, claims must be
3 filed within 180 days after the Department determines the
4 applicant is eligible. For claims for which the Illinois
5 Department is not the primary payer, claims must be submitted
6 to the Illinois Department within 180 days after the final
7 adjudication by the primary payer.

8 In the case of long term care facilities, within 45
9 calendar days of receipt by the facility of required
10 prescreening information, new admissions with associated
11 admission documents shall be submitted through the Medical
12 Electronic Data Interchange (MEDI) or the Recipient
13 Eligibility Verification (REV) System or shall be submitted
14 directly to the Department of Human Services using required
15 admission forms. Effective September 1, 2014, admission
16 documents, including all prescreening information, must be
17 submitted through MEDI or REV. Confirmation numbers assigned to
18 an accepted transaction shall be retained by a facility to
19 verify timely submittal. Once an admission transaction has been
20 completed, all resubmitted claims following prior rejection
21 are subject to receipt no later than 180 days after the
22 admission transaction has been completed.

23 Claims that are not submitted and received in compliance
24 with the foregoing requirements shall not be eligible for
25 payment under the medical assistance program, and the State
26 shall have no liability for payment of those claims.

1 To the extent consistent with applicable information and
2 privacy, security, and disclosure laws, State and federal
3 agencies and departments shall provide the Illinois Department
4 access to confidential and other information and data necessary
5 to perform eligibility and payment verifications and other
6 Illinois Department functions. This includes, but is not
7 limited to: information pertaining to licensure;
8 certification; earnings; immigration status; citizenship; wage
9 reporting; unearned and earned income; pension income;
10 employment; supplemental security income; social security
11 numbers; National Provider Identifier (NPI) numbers; the
12 National Practitioner Data Bank (NPDB); program and agency
13 exclusions; taxpayer identification numbers; tax delinquency;
14 corporate information; and death records.

15 The Illinois Department shall enter into agreements with
16 State agencies and departments, and is authorized to enter into
17 agreements with federal agencies and departments, under which
18 such agencies and departments shall share data necessary for
19 medical assistance program integrity functions and oversight.
20 The Illinois Department shall develop, in cooperation with
21 other State departments and agencies, and in compliance with
22 applicable federal laws and regulations, appropriate and
23 effective methods to share such data. At a minimum, and to the
24 extent necessary to provide data sharing, the Illinois
25 Department shall enter into agreements with State agencies and
26 departments, and is authorized to enter into agreements with

1 federal agencies and departments, including but not limited to:
2 the Secretary of State; the Department of Revenue; the
3 Department of Public Health; the Department of Human Services;
4 and the Department of Financial and Professional Regulation.

5 Beginning in fiscal year 2013, the Illinois Department
6 shall set forth a request for information to identify the
7 benefits of a pre-payment, post-adjudication, and post-edit
8 claims system with the goals of streamlining claims processing
9 and provider reimbursement, reducing the number of pending or
10 rejected claims, and helping to ensure a more transparent
11 adjudication process through the utilization of: (i) provider
12 data verification and provider screening technology; and (ii)
13 clinical code editing; and (iii) pre-pay, pre- or
14 post-adjudicated predictive modeling with an integrated case
15 management system with link analysis. Such a request for
16 information shall not be considered as a request for proposal
17 or as an obligation on the part of the Illinois Department to
18 take any action or acquire any products or services.

19 The Illinois Department shall establish policies,
20 procedures, standards and criteria by rule for the acquisition,
21 repair and replacement of orthotic and prosthetic devices and
22 durable medical equipment. Such rules shall provide, but not be
23 limited to, the following services: (1) immediate repair or
24 replacement of such devices by recipients; and (2) rental,
25 lease, purchase or lease-purchase of durable medical equipment
26 in a cost-effective manner, taking into consideration the

1 recipient's medical prognosis, the extent of the recipient's
2 needs, and the requirements and costs for maintaining such
3 equipment. Subject to prior approval, such rules shall enable a
4 recipient to temporarily acquire and use alternative or
5 substitute devices or equipment pending repairs or
6 replacements of any device or equipment previously authorized
7 for such recipient by the Department. Notwithstanding any
8 provision of Section 5-5f to the contrary, the Department may,
9 by rule, exempt certain replacement wheelchair parts from prior
10 approval and, for wheelchairs, wheelchair parts, wheelchair
11 accessories, and related seating and positioning items,
12 determine the wholesale price by methods other than actual
13 acquisition costs.

14 The Department shall require, by rule, all providers of
15 durable medical equipment to be accredited by an accreditation
16 organization approved by the federal Centers for Medicare and
17 Medicaid Services and recognized by the Department in order to
18 bill the Department for providing durable medical equipment to
19 recipients. No later than 15 months after the effective date of
20 the rule adopted pursuant to this paragraph, all providers must
21 meet the accreditation requirement.

22 The Department shall execute, relative to the nursing home
23 prescreening project, written inter-agency agreements with the
24 Department of Human Services and the Department on Aging, to
25 effect the following: (i) intake procedures and common
26 eligibility criteria for those persons who are receiving

1 non-institutional services; and (ii) the establishment and
2 development of non-institutional services in areas of the State
3 where they are not currently available or are undeveloped; and
4 (iii) notwithstanding any other provision of law, subject to
5 federal approval, on and after July 1, 2012, an increase in the
6 determination of need (DON) scores from 29 to 37 for applicants
7 for institutional and home and community-based long term care;
8 if and only if federal approval is not granted, the Department
9 may, in conjunction with other affected agencies, implement
10 utilization controls or changes in benefit packages to
11 effectuate a similar savings amount for this population; and
12 (iv) no later than July 1, 2013, minimum level of care
13 eligibility criteria for institutional and home and
14 community-based long term care; and (v) no later than October
15 1, 2013, establish procedures to permit long term care
16 providers access to eligibility scores for individuals with an
17 admission date who are seeking or receiving services from the
18 long term care provider. In order to select the minimum level
19 of care eligibility criteria, the Governor shall establish a
20 workgroup that includes affected agency representatives and
21 stakeholders representing the institutional and home and
22 community-based long term care interests. This Section shall
23 not restrict the Department from implementing lower level of
24 care eligibility criteria for community-based services in
25 circumstances where federal approval has been granted.

26 The Illinois Department shall develop and operate, in

1 cooperation with other State Departments and agencies and in
2 compliance with applicable federal laws and regulations,
3 appropriate and effective systems of health care evaluation and
4 programs for monitoring of utilization of health care services
5 and facilities, as it affects persons eligible for medical
6 assistance under this Code.

7 The Illinois Department shall report annually to the
8 General Assembly, no later than the second Friday in April of
9 1979 and each year thereafter, in regard to:

10 (a) actual statistics and trends in utilization of
11 medical services by public aid recipients;

12 (b) actual statistics and trends in the provision of
13 the various medical services by medical vendors;

14 (c) current rate structures and proposed changes in
15 those rate structures for the various medical vendors; and

16 (d) efforts at utilization review and control by the
17 Illinois Department.

18 The period covered by each report shall be the 3 years
19 ending on the June 30 prior to the report. The report shall
20 include suggested legislation for consideration by the General
21 Assembly. The filing of one copy of the report with the
22 Speaker, one copy with the Minority Leader and one copy with
23 the Clerk of the House of Representatives, one copy with the
24 President, one copy with the Minority Leader and one copy with
25 the Secretary of the Senate, one copy with the Legislative
26 Research Unit, and such additional copies with the State

1 Government Report Distribution Center for the General Assembly
2 as is required under paragraph (t) of Section 7 of the State
3 Library Act shall be deemed sufficient to comply with this
4 Section.

5 Rulemaking authority to implement Public Act 95-1045, if
6 any, is conditioned on the rules being adopted in accordance
7 with all provisions of the Illinois Administrative Procedure
8 Act and all rules and procedures of the Joint Committee on
9 Administrative Rules; any purported rule not so adopted, for
10 whatever reason, is unauthorized.

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

16 Because kidney transplantation can be an appropriate, cost
17 effective alternative to renal dialysis when medically
18 necessary and notwithstanding the provisions of Section 1-11 of
19 this Code, beginning October 1, 2014, the Department shall
20 cover kidney transplantation for noncitizens with end-stage
21 renal disease who are not eligible for comprehensive medical
22 benefits, who meet the residency requirements of Section 5-3 of
23 this Code, and who would otherwise meet the financial
24 requirements of the appropriate class of eligible persons under
25 Section 5-2 of this Code. To qualify for coverage of kidney
26 transplantation, such person must be receiving emergency renal

1 dialysis services covered by the Department. Providers under
2 this Section shall be prior approved and certified by the
3 Department to perform kidney transplantation and the services
4 under this Section shall be limited to services associated with
5 kidney transplantation.

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

17 On or after July 1, 2015, opioid antagonists prescribed for
18 the treatment of an opioid overdose, including the medication
19 product, administration devices, and any pharmacy fees related
20 to the dispensing and administration of the opioid antagonist,
21 shall be covered under the medical assistance program for
22 persons who are otherwise eligible for medical assistance under
23 this Article. As used in this Section, "opioid antagonist"
24 means a drug that binds to opioid receptors and blocks or
25 inhibits the effect of opioids acting on those receptors,
26 including, but not limited to, naloxone hydrochloride or any

1 other similarly acting drug approved by the U.S. Food and Drug
2 Administration.

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

15 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
16 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
17 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;
18 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
19 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,
20 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
21 100-538, eff. 1-1-18; revised 10-26-17.)

22 (305 ILCS 5/5-30)

23 Sec. 5-30. Care coordination.

24 (a) At least 50% of recipients eligible for comprehensive
25 medical benefits in all medical assistance programs or other

1 health benefit programs administered by the Department,
2 including the Children's Health Insurance Program Act and the
3 Covering ALL KIDS Health Insurance Act, shall be enrolled in a
4 care coordination program by no later than January 1, 2015. For
5 purposes of this Section, "coordinated care" or "care
6 coordination" means delivery systems where recipients will
7 receive their care from providers who participate under
8 contract in integrated delivery systems that are responsible
9 for providing or arranging the majority of care, including
10 primary care physician services, referrals from primary care
11 physicians, diagnostic and treatment services, behavioral
12 health services, in-patient and outpatient hospital services,
13 dental services, and rehabilitation and long-term care
14 services. The Department shall designate or contract for such
15 integrated delivery systems (i) to ensure enrollees have a
16 choice of systems and of primary care providers within such
17 systems; (ii) to ensure that enrollees receive quality care in
18 a culturally and linguistically appropriate manner; and (iii)
19 to ensure that coordinated care programs meet the diverse needs
20 of enrollees with developmental, mental health, physical, and
21 age-related disabilities.

22 (b) Payment for such coordinated care shall be based on
23 arrangements where the State pays for performance related to
24 health care outcomes, the use of evidence-based practices, the
25 use of primary care delivered through comprehensive medical
26 homes, the use of electronic medical records, and the

1 appropriate exchange of health information electronically made
2 either on a capitated basis in which a fixed monthly premium
3 per recipient is paid and full financial risk is assumed for
4 the delivery of services, or through other risk-based payment
5 arrangements.

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

16 (d) The Department shall report to the General Assembly in
17 a separate part of its annual medical assistance program
18 report, beginning April, 2012 until April, 2016, on the
19 progress and implementation of the care coordination program
20 initiatives established by the provisions of Public Act
21 96-1501. The Department shall include in its April 2011 report
22 a full analysis of federal laws or regulations regarding upper
23 payment limitations to providers and the necessary revisions or
24 adjustments in rate methodologies and payments to providers
25 under this Code that would be necessary to implement
26 coordinated care with full financial risk by a party other than

1 the Department.

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

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

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

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

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

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

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

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

11 (f) A hospital that is located in a county of the State in
12 which the Department mandates some or all of the beneficiaries
13 of the Medical Assistance Program residing in the county to
14 enroll in a Care Coordination Program, as set forth in Section
15 5-30 of this Code, shall not be eligible for any non-claims
16 based payments not mandated by Article V-A of this Code for
17 which it would otherwise be qualified to receive, unless the
18 hospital is a Coordinated Care Participating Hospital no later
19 than 60 days after June 14, 2012 (the effective date of Public
20 Act 97-689) or 60 days after the first mandatory enrollment of
21 a beneficiary in a Coordinated Care program. For purposes of
22 this subsection, "Coordinated Care Participating Hospital"
23 means a hospital that meets one of the following criteria:

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

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

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

14 (g) No later than August 1, 2013, the Department shall
15 issue a purchase of care solicitation for Accountable Care
16 Entities (ACE) to serve any children and parents or caretaker
17 relatives of children eligible for medical assistance under
18 this Article. An ACE may be a single corporate structure or a
19 network of providers organized through contractual
20 relationships with a single corporate entity. The solicitation
21 shall require that:

22 (1) An ACE operating in Cook County be capable of
23 serving at least 40,000 eligible individuals in that
24 county; an ACE operating in Lake, Kane, DuPage, or Will
25 Counties be capable of serving at least 20,000 eligible
26 individuals in those counties and an ACE operating in other

1 regions of the State be capable of serving at least 10,000
2 eligible individuals in the region in which it operates.
3 During initial periods of mandatory enrollment, the
4 Department shall require its enrollment services
5 contractor to use a default assignment algorithm that
6 ensures if possible an ACE reaches the minimum enrollment
7 levels set forth in this paragraph.

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

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

15 (4) An ACE must be an integrated delivery system,
16 including a network able to provide the full range of
17 services needed by Medicaid beneficiaries and system
18 capacity to securely pass clinical information across
19 participating entities and to aggregate and analyze that
20 data in order to coordinate care.

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

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

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

18 (8) In the fourth and subsequent years of operation, an
19 ACE shall convert to a Managed Care Community Network
20 (MCCN), as defined in this Article, or Health Maintenance
21 Organization pursuant to the Illinois Insurance Code,
22 accepting full-risk capitation payments.

23 The Department shall allow potential ACE entities 5 months
24 from the date of the posting of the solicitation to submit
25 proposals. After the solicitation is released, in addition to
26 the MCO rate development data available on the Department's

1 website, subject to federal and State confidentiality and
2 privacy laws and regulations, the Department shall provide 2
3 years of de-identified summary service data on the targeted
4 population, split between children and adults, showing the
5 historical type and volume of services received and the cost of
6 those services to those potential bidders that sign a data use
7 agreement. The Department may add up to 2 non-state government
8 employees with expertise in creating integrated delivery
9 systems to its review team for the purchase of care
10 solicitation described in this subsection. Any such
11 individuals must sign a no-conflict disclosure and
12 confidentiality agreement and agree to act in accordance with
13 all applicable State laws.

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

17 Nothing in this subsection shall be construed to limit the
18 Department's mandate to enroll 50% of its beneficiaries into
19 care coordination systems by January 1, 2015, using all
20 available care coordination delivery systems, including Care
21 Coordination Entities (CCE), MCCNs, or MCOs, nor be construed
22 to affect the current CCEs, MCCNs, and MCOs selected to serve
23 seniors and persons with disabilities prior to that date.

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

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

19 (h-5) The Department shall monitor and enforce compliance
20 by MCOs with agreements they have entered into with providers
21 on issues that include, but are not limited to, timeliness of
22 payment, payment rates, and processes for obtaining prior
23 approval. The Department may impose sanctions on MCOs for
24 violating provisions of those agreements that include, but are
25 not limited to, financial penalties, suspension of enrollment
26 of new enrollees, and termination of the MCO's contract with

1 the Department. As used in this subsection (h-5), "MCO" has the
2 meaning ascribed to that term in Section 5-30.1 of this Code.

3 (i) Unless otherwise required by federal law, Medicaid
4 Managed Care Entities and their respective business associates
5 shall not disclose, directly or indirectly, including by
6 sending a bill or explanation of benefits, information
7 concerning the sensitive health services received by enrollees
8 of the Medicaid Managed Care Entity to any person other than
9 covered entities and business associates, which may receive,
10 use, and further disclose such information solely for the
11 purposes permitted under applicable federal and State laws and
12 regulations if such use and further disclosure satisfies all
13 applicable requirements of such laws and regulations. The
14 Medicaid Managed Care Entity or its respective business
15 associates may disclose information concerning the sensitive
16 health services if the enrollee who received the sensitive
17 health services requests the information from the Medicaid
18 Managed Care Entity or its respective business associates and
19 authorized the sending of a bill or explanation of benefits.
20 Communications including, but not limited to, statements of
21 care received or appointment reminders either directly or
22 indirectly to the enrollee from the health care provider,
23 health care professional, and care coordinators, remain
24 permissible. Medicaid Managed Care Entities or their
25 respective business associates may communicate directly with
26 their enrollees regarding care coordination activities for

1 those enrollees.

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

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

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

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

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

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

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

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

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

20 (4) Data tracking that identifies the language need.

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

24 (k) The Department shall actively monitor the contractual
25 relationship between Managed Care Organizations (MCOs) and any
26 dental administrator contracted by an MCO to provide dental

1 services. The Department shall adopt appropriate dental
2 Healthcare Effectiveness Data and Information Set measures or
3 other dental quality performance measures as part of its
4 monitoring and shall include additional specific dental
5 performance measurers in its Health Plan Comparison Tool and
6 Illinois Medicaid Plan Report Card that is available on the
7 Department's website for enrolled individuals.

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

13 (l) No health plan or its subcontractors by contract,
14 written policy, or procedure shall contain any clause
15 attempting to limit the right of medical assistance recipients
16 under any medical assistance program administered by the
17 Department to obtain dental services from any qualified
18 Medicaid provider who undertakes to provide those services.

19 (m) Notwithstanding any other law to the contrary, the
20 Department shall not adopt any rule or enter into any contract
21 that prohibits an individual licensed to practice dentistry or
22 dental hygiene under the Illinois Dental Practice Act from
23 receiving reimbursement under the medical assistance program
24 for a dental encounter.

25 (Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14;
26 99-106, eff. 1-1-16; 99-181, eff. 7-29-15; 99-566, eff. 1-1-17;

1 99-642, eff. 7-28-16.)

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