



Sen. Omar Aquino

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1 AMENDMENT TO SENATE BILL 2429

2 AMENDMENT NO. _____. Amend Senate Bill 2429 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Public Aid Code is amended by
5 changing Sections 5-5, 5-30, and 5-30.1 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

1 care furnished by licensed practitioners; (7) home health care
2 services; (8) private duty nursing service; (9) clinic
3 services; (10) dental services, including prevention and
4 treatment of periodontal disease and dental caries disease for
5 pregnant women, provided by an individual licensed to practice
6 dentistry or dental surgery; for purposes of this item (10),
7 "dental services" means diagnostic, preventive, or corrective
8 procedures provided by or under the supervision of a dentist in
9 the practice of his or her profession; (11) physical therapy
10 and related services; (12) prescribed drugs, dentures, and
11 prosthetic devices; and eyeglasses prescribed by a physician
12 skilled in the diseases of the eye, or by an optometrist,
13 whichever the person may select; (13) other diagnostic,
14 screening, preventive, and rehabilitative services, including
15 to ensure that the individual's need for intervention or
16 treatment of mental disorders or substance use disorders or
17 co-occurring mental health and substance use disorders is
18 determined using a uniform screening, assessment, and
19 evaluation process inclusive of criteria, for children and
20 adults; for purposes of this item (13), a uniform screening,
21 assessment, and evaluation process refers to a process that
22 includes an appropriate evaluation and, as warranted, a
23 referral; "uniform" does not mean the use of a singular
24 instrument, tool, or process that all must utilize; (14)
25 transportation and such other expenses as may be necessary;
26 (15) medical treatment of sexual assault survivors, as defined

1 in Section 1a of the Sexual Assault Survivors Emergency
2 Treatment Act, for injuries sustained as a result of the sexual
3 assault, including examinations and laboratory tests to
4 discover evidence which may be used in criminal proceedings
5 arising from the sexual assault; (16) the diagnosis and
6 treatment of sickle cell anemia; and (17) any other medical
7 care, and any other type of remedial care recognized under the
8 laws of this State. The term "any other type of remedial care"
9 shall include nursing care and nursing home service for persons
10 who rely on treatment by spiritual means alone through prayer
11 for healing.

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

19 Notwithstanding any other provision of this Code,
20 reproductive health care that is otherwise legal in Illinois
21 shall be covered under the medical assistance program for
22 persons who are otherwise eligible for medical assistance under
23 this Article.

24 Notwithstanding any other provision of this Code, the
25 Illinois Department may not require, as a condition of payment
26 for any laboratory test authorized under this Article, that a

1 physician's handwritten signature appear on the laboratory
2 test order form. The Illinois Department may, however, impose
3 other appropriate requirements regarding laboratory test order
4 documentation.

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

23 On and after July 1, 2012, the Department of Healthcare and
24 Family Services may provide the following services to persons
25 eligible for assistance under this Article who are
26 participating in education, training or employment programs

1 operated by the Department of Human Services as successor to
2 the Department of Public Aid:

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

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

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

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

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

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

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

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

26 The Illinois Department shall authorize the provision of,

1 and shall authorize payment for, screening by low-dose
2 mammography for the presence of occult breast cancer for women
3 35 years of age or older who are eligible for medical
4 assistance under this Article, as follows:

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

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

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

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

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

22 All screenings shall include a physical breast exam,
23 instruction on self-examination and information regarding the
24 frequency of self-examination and its value as a preventative
25 tool. For purposes of this Section, "low-dose mammography"
26 means the x-ray examination of the breast using equipment

1 dedicated specifically for mammography, including the x-ray
2 tube, filter, compression device, and image receptor, with an
3 average radiation exposure delivery of less than one rad per
4 breast for 2 views of an average size breast. The term also
5 includes digital mammography and includes breast
6 tomosynthesis. As used in this Section, the term "breast
7 tomosynthesis" means a radiologic procedure that involves the
8 acquisition of projection images over the stationary breast to
9 produce cross-sectional digital three-dimensional images of
10 the breast. If, at any time, the Secretary of the United States
11 Department of Health and Human Services, or its successor
12 agency, promulgates rules or regulations to be published in the
13 Federal Register or publishes a comment in the Federal Register
14 or issues an opinion, guidance, or other action that would
15 require the State, pursuant to any provision of the Patient
16 Protection and Affordable Care Act (Public Law 111-148),
17 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
18 successor provision, to defray the cost of any coverage for
19 breast tomosynthesis outlined in this paragraph, then the
20 requirement that an insurer cover breast tomosynthesis is
21 inoperative other than any such coverage authorized under
22 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
23 the State shall not assume any obligation for the cost of
24 coverage for breast tomosynthesis set forth in this paragraph.

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

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

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

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

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

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

24 Subject to federal approval, the Department shall
25 establish a rate methodology for mammography at federally
26 qualified health centers and other encounter-rate clinics.

1 These clinics or centers may also collaborate with other
2 hospital-based mammography facilities. By January 1, 2016, the
3 Department shall report to the General Assembly on the status
4 of the provision set forth in this paragraph.

5 The Department shall establish a methodology to remind
6 women who are age-appropriate for screening mammography, but
7 who have not received a mammogram within the previous 18
8 months, of the importance and benefit of screening mammography.
9 The Department shall work with experts in breast cancer
10 outreach and patient navigation to optimize these reminders and
11 shall establish a methodology for evaluating their
12 effectiveness and modifying the methodology based on the
13 evaluation.

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

20 The Department shall devise a means of case-managing or
21 patient navigation for beneficiaries diagnosed with breast
22 cancer. This program shall initially operate as a pilot program
23 in areas of the State with the highest incidence of mortality
24 related to breast cancer. At least one pilot program site shall
25 be in the metropolitan Chicago area and at least one site shall
26 be outside the metropolitan Chicago area. On or after July 1,

1 2016, the pilot program shall be expanded to include one site
2 in western Illinois, one site in southern Illinois, one site in
3 central Illinois, and 4 sites within metropolitan Chicago. An
4 evaluation of the pilot program shall be carried out measuring
5 health outcomes and cost of care for those served by the pilot
6 program compared to similarly situated patients who are not
7 served by the pilot program.

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

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

1 Human Services.

2 All medical providers providing medical assistance to
3 pregnant women under this Code shall receive information from
4 the Department on the availability of services under the Drug
5 Free Families with a Future or any comparable program providing
6 case management services for addicted women, including
7 information on appropriate referrals for other social services
8 that may be needed by addicted women in addition to treatment
9 for addiction.

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

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

21 The Illinois Department shall establish such regulations
22 governing the dispensing of health services under this Article
23 as it shall deem appropriate. The Department should seek the
24 advice of formal professional advisory committees appointed by
25 the Director of the Illinois Department for the purpose of
26 providing regular advice on policy and administrative matters,

1 information dissemination and educational activities for
2 medical and health care providers, and consistency in
3 procedures to the Illinois Department.

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

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

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

1 services.

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

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

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

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

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

4 The Illinois Department shall require health care
5 providers to maintain records that document the medical care
6 and services provided to recipients of Medical Assistance under
7 this Article. Such records must be retained for a period of not
8 less than 6 years from the date of service or as provided by
9 applicable State law, whichever period is longer, except that
10 if an audit is initiated within the required retention period
11 then the records must be retained until the audit is completed
12 and every exception is resolved. The Illinois Department shall
13 require health care providers to make available, when
14 authorized by the patient, in writing, the medical records in a
15 timely fashion to other health care providers who are treating
16 or serving persons eligible for Medical Assistance under this
17 Article. All dispensers of medical services shall be required
18 to maintain and retain business and professional records
19 sufficient to fully and accurately document the nature, scope,
20 details and receipt of the health care provided to persons
21 eligible for medical assistance under this Code, in accordance
22 with regulations promulgated by the Illinois Department. The
23 rules and regulations shall require that proof of the receipt
24 of prescription drugs, dentures, prosthetic devices and
25 eyeglasses by eligible persons under this Section accompany
26 each claim for reimbursement submitted by the dispenser of such

1 medical services. No such claims for reimbursement shall be
2 approved for payment by the Illinois Department without such
3 proof of receipt, unless the Illinois Department shall have put
4 into effect and shall be operating a system of post-payment
5 audit and review which shall, on a sampling basis, be deemed
6 adequate by the Illinois Department to assure that such drugs,
7 dentures, prosthetic devices and eyeglasses for which payment
8 is being made are actually being received by eligible
9 recipients. Within 90 days after September 16, 1984 (the
10 effective date of Public Act 83-1439), the Illinois Department
11 shall establish a current list of acquisition costs for all
12 prosthetic devices and any other items recognized as medical
13 equipment and supplies reimbursable under this Article and
14 shall update such list on a quarterly basis, except that the
15 acquisition costs of all prescription drugs shall be updated no
16 less frequently than every 30 days as required by Section
17 5-5.12.

18 Notwithstanding any other law to the contrary, the Illinois
19 Department shall, within 365 days after July 22, 2013 (the
20 effective date of Public Act 98-104), establish procedures to
21 permit skilled care facilities licensed under the Nursing Home
22 Care Act to submit monthly billing claims for reimbursement
23 purposes. Following development of these procedures, the
24 Department shall, by July 1, 2016, test the viability of the
25 new system and implement any necessary operational or
26 structural changes to its information technology platforms in

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

3 Notwithstanding any other law to the contrary, the Illinois
4 Department shall, within 365 days after August 15, 2014 (the
5 effective date of Public Act 98-963), establish procedures to
6 permit ID/DD facilities licensed under the ID/DD Community Care
7 Act and MC/DD facilities licensed under the MC/DD Act to submit
8 monthly billing claims for reimbursement purposes. Following
9 development of these procedures, the Department shall have an
10 additional 365 days to test the viability of the new system and
11 to ensure that any necessary operational or structural changes
12 to its information technology platforms are implemented.

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

22 The Illinois Department may require that all dispensers of
23 medical services desiring to participate in the medical
24 assistance program established under this Article disclose,
25 under such terms and conditions as the Illinois Department may
26 by rule establish, all inquiries from clients and attorneys

1 regarding medical bills paid by the Illinois Department, which
2 inquiries could indicate potential existence of claims or liens
3 for the Illinois Department.

4 Enrollment of a vendor shall be subject to a provisional
5 period and shall be conditional for one year. During the period
6 of conditional enrollment, the Department may terminate the
7 vendor's eligibility to participate in, or may disenroll the
8 vendor from, the medical assistance program without cause.
9 Unless otherwise specified, such termination of eligibility or
10 disenrollment is not subject to the Department's hearing
11 process. However, a disenrolled vendor may reapply without
12 penalty.

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

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

1 screening as required by federal or State law.

2 The Department shall define or specify the following: (i)
3 by provider notice, the "category of risk of the vendor" for
4 each type of vendor, which shall take into account the level of
5 screening applicable to a particular category of vendor under
6 federal law and regulations; (ii) by rule or provider notice,
7 the maximum length of the conditional enrollment period for
8 each category of risk of the vendor; and (iii) by rule, the
9 hearing rights, if any, afforded to a vendor in each category
10 of risk of the vendor that is terminated or disenrolled during
11 the conditional enrollment period.

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

19 (1) In the case of a provider whose enrollment is in
20 process by the Illinois Department, the 180-day period
21 shall not begin until the date on the written notice from
22 the Illinois Department that the provider enrollment is
23 complete.

24 (2) In the case of errors attributable to the Illinois
25 Department or any of its claims processing intermediaries
26 which result in an inability to receive, process, or

1 adjudicate a claim, the 180-day period shall not begin
2 until the provider has been notified of the error.

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

5 (4) In the case of a provider operated by a unit of
6 local government with a population exceeding 3,000,000
7 when local government funds finance federal participation
8 for claims payments.

9 For claims for services rendered during a period for which
10 a recipient received retroactive eligibility, claims must be
11 filed within 180 days after the Department determines the
12 applicant is eligible. For claims for which the Illinois
13 Department is not the primary payer, claims must be submitted
14 to the Illinois Department within 180 days after the final
15 adjudication by the primary payer.

16 In the case of long term care facilities, within 45
17 calendar days of receipt by the facility of required
18 prescreening information, new admissions with associated
19 admission documents shall be submitted through the Medical
20 Electronic Data Interchange (MEDI) or the Recipient
21 Eligibility Verification (REV) System or shall be submitted
22 directly to the Department of Human Services using required
23 admission forms. Effective September 1, 2014, admission
24 documents, including all prescreening information, must be
25 submitted through MEDI or REV. Confirmation numbers assigned to
26 an accepted transaction shall be retained by a facility to

1 verify timely submittal. Once an admission transaction has been
2 completed, all resubmitted claims following prior rejection
3 are subject to receipt no later than 180 days after the
4 admission transaction has been completed.

5 Claims that are not submitted and received in compliance
6 with the foregoing requirements shall not be eligible for
7 payment under the medical assistance program, and the State
8 shall have no liability for payment of those claims.

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

23 The Illinois Department shall enter into agreements with
24 State agencies and departments, and is authorized to enter into
25 agreements with federal agencies and departments, under which
26 such agencies and departments shall share data necessary for

1 medical assistance program integrity functions and oversight.
2 The Illinois Department shall develop, in cooperation with
3 other State departments and agencies, and in compliance with
4 applicable federal laws and regulations, appropriate and
5 effective methods to share such data. At a minimum, and to the
6 extent necessary to provide data sharing, the Illinois
7 Department shall enter into agreements with State agencies and
8 departments, and is authorized to enter into agreements with
9 federal agencies and departments, including but not limited to:
10 the Secretary of State; the Department of Revenue; the
11 Department of Public Health; the Department of Human Services;
12 and the Department of Financial and Professional Regulation.

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

1 The Illinois Department shall establish policies,
2 procedures, standards and criteria by rule for the acquisition,
3 repair and replacement of orthotic and prosthetic devices and
4 durable medical equipment. Such rules shall provide, but not be
5 limited to, the following services: (1) immediate repair or
6 replacement of such devices by recipients; and (2) rental,
7 lease, purchase or lease-purchase of durable medical equipment
8 in a cost-effective manner, taking into consideration the
9 recipient's medical prognosis, the extent of the recipient's
10 needs, and the requirements and costs for maintaining such
11 equipment. Subject to prior approval, such rules shall enable a
12 recipient to temporarily acquire and use alternative or
13 substitute devices or equipment pending repairs or
14 replacements of any device or equipment previously authorized
15 for such recipient by the Department. Notwithstanding any
16 provision of Section 5-5f to the contrary, the Department may,
17 by rule, exempt certain replacement wheelchair parts from prior
18 approval and, for wheelchairs, wheelchair parts, wheelchair
19 accessories, and related seating and positioning items,
20 determine the wholesale price by methods other than actual
21 acquisition costs.

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

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

4 The Department shall execute, relative to the nursing home
5 prescreening project, written inter-agency agreements with the
6 Department of Human Services and the Department on Aging, to
7 effect the following: (i) intake procedures and common
8 eligibility criteria for those persons who are receiving
9 non-institutional services; and (ii) the establishment and
10 development of non-institutional services in areas of the State
11 where they are not currently available or are undeveloped; and
12 (iii) notwithstanding any other provision of law, subject to
13 federal approval, on and after July 1, 2012, an increase in the
14 determination of need (DON) scores from 29 to 37 for applicants
15 for institutional and home and community-based long term care;
16 if and only if federal approval is not granted, the Department
17 may, in conjunction with other affected agencies, implement
18 utilization controls or changes in benefit packages to
19 effectuate a similar savings amount for this population; and
20 (iv) no later than July 1, 2013, minimum level of care
21 eligibility criteria for institutional and home and
22 community-based long term care; and (v) no later than October
23 1, 2013, establish procedures to permit long term care
24 providers access to eligibility scores for individuals with an
25 admission date who are seeking or receiving services from the
26 long term care provider. In order to select the minimum level

1 of care eligibility criteria, the Governor shall establish a
2 workgroup that includes affected agency representatives and
3 stakeholders representing the institutional and home and
4 community-based long term care interests. This Section shall
5 not restrict the Department from implementing lower level of
6 care eligibility criteria for community-based services in
7 circumstances where federal approval has been granted.

8 The Illinois Department shall develop and operate, in
9 cooperation with other State Departments and agencies and in
10 compliance with applicable federal laws and regulations,
11 appropriate and effective systems of health care evaluation and
12 programs for monitoring of utilization of health care services
13 and facilities, as it affects persons eligible for medical
14 assistance under this Code.

15 The Illinois Department shall report annually to the
16 General Assembly, no later than the second Friday in April of
17 1979 and each year thereafter, in regard to:

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

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

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

24 (d) efforts at utilization review and control by the
25 Illinois Department.

26 The period covered by each report shall be the 3 years

1 ending on the June 30 prior to the report. The report shall
2 include suggested legislation for consideration by the General
3 Assembly. The filing of one copy of the report with the
4 Speaker, one copy with the Minority Leader and one copy with
5 the Clerk of the House of Representatives, one copy with the
6 President, one copy with the Minority Leader and one copy with
7 the Secretary of the Senate, one copy with the Legislative
8 Research Unit, and such additional copies with the State
9 Government Report Distribution Center for the General Assembly
10 as is required under paragraph (t) of Section 7 of the State
11 Library Act shall be deemed sufficient to comply with this
12 Section.

13 Rulemaking authority to implement Public Act 95-1045, if
14 any, is conditioned on the rules being adopted in accordance
15 with all provisions of the Illinois Administrative Procedure
16 Act and all rules and procedures of the Joint Committee on
17 Administrative Rules; any purported rule not so adopted, for
18 whatever reason, is unauthorized.

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

24 Because kidney transplantation can be an appropriate, cost
25 effective alternative to renal dialysis when medically
26 necessary and notwithstanding the provisions of Section 1-11 of

1 this Code, beginning October 1, 2014, the Department shall
2 cover kidney transplantation for noncitizens with end-stage
3 renal disease who are not eligible for comprehensive medical
4 benefits, who meet the residency requirements of Section 5-3 of
5 this Code, and who would otherwise meet the financial
6 requirements of the appropriate class of eligible persons under
7 Section 5-2 of this Code. To qualify for coverage of kidney
8 transplantation, such person must be receiving emergency renal
9 dialysis services covered by the Department. Providers under
10 this Section shall be prior approved and certified by the
11 Department to perform kidney transplantation and the services
12 under this Section shall be limited to services associated with
13 kidney transplantation.

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

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

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

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

23 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
24 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
25 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;
26 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.

1 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,
2 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
3 100-538, eff. 1-1-18; revised 10-26-17.)

4 (305 ILCS 5/5-30)

5 Sec. 5-30. Care coordination.

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

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

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

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

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

1 progress and implementation of the care coordination program
2 initiatives established by the provisions of Public Act
3 96-1501. The Department shall include in its April 2011 report
4 a full analysis of federal laws or regulations regarding upper
5 payment limitations to providers and the necessary revisions or
6 adjustments in rate methodologies and payments to providers
7 under this Code that would be necessary to implement
8 coordinated care with full financial risk by a party other than
9 the Department.

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

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

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

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

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

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

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

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

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

19 (f) A hospital that is located in a county of the State in
20 which the Department mandates some or all of the beneficiaries
21 of the Medical Assistance Program residing in the county to
22 enroll in a Care Coordination Program, as set forth in Section
23 5-30 of this Code, shall not be eligible for any non-claims
24 based payments not mandated by Article V-A of this Code for
25 which it would otherwise be qualified to receive, unless the
26 hospital is a Coordinated Care Participating Hospital no later

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 language assistance services.

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

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

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

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

21 (Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14;
22 99-106, eff. 1-1-16; 99-181, eff. 7-29-15; 99-566, eff. 1-1-17;
23 99-642, eff. 7-28-16.)

24 (305 ILCS 5/5-30.1)

25 Sec. 5-30.1. Managed care protections.

1 (a) As used in this Section:

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

5 "Emergency services" include:

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

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

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

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

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

20 (c) An MCO shall pay any provider of emergency services
21 that does not have in effect a contract with the contracted
22 Medicaid MCO. The default rate of reimbursement shall be the
23 rate paid under Illinois Medicaid fee-for-service program
24 methodology, including all policy adjusters, including but not
25 limited to Medicaid High Volume Adjustments, Medicaid
26 Percentage Adjustments, Outpatient High Volume Adjustments,

1 and all outlier add-on adjustments to the extent such
2 adjustments are incorporated in the development of the
3 applicable MCO capitated rates.

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

6 (1) the MCO authorized such services;

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

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

13 (4) the MCO could not be contacted; or

14 (5) the MCO and the treating provider, if the treating
15 provider is a non-affiliated provider, could not reach an
16 agreement concerning the enrollee's care and an affiliated
17 provider was unavailable for a consultation, in which case
18 the MCO must pay for such services rendered by the treating
19 non-affiliated provider until an affiliated provider was
20 reached and either concurred with the treating
21 non-affiliated provider's plan of care or assumed
22 responsibility for the enrollee's care. Such payment shall
23 be made at the default rate of reimbursement paid under
24 Illinois Medicaid fee-for-service program methodology,
25 including all policy adjusters, including but not limited
26 to Medicaid High Volume Adjustments, Medicaid Percentage

1 Adjustments, Outpatient High Volume Adjustments and all
2 outlier add-on adjustments to the extent that such
3 adjustments are incorporated in the development of the
4 applicable MCO capitated rates.

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

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

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

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

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

21 (5) The determination of the attending emergency
22 physician, or the provider actually treating the enrollee,
23 of whether an enrollee is sufficiently stabilized for
24 discharge or transfer to another facility, shall be binding
25 on the MCO. The MCO shall cover emergency services for all
26 enrollees whether the emergency services are provided by an

1 affiliated or non-affiliated provider.

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

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

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

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

13 (D) the enrollee is discharged.

14 (f) Network adequacy and transparency.

15 (1) The Department shall:

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

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

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

23 (D) require MCOs, including Medicaid Managed Care
24 Entities as defined in Section 5-30.2, to meet provider
25 directory requirements under Section 5-30.3.

26 (2) Each MCO shall confirm its receipt of information

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

9 (g) Timely payment of claims.

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

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

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

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

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

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

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

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

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

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

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

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

1 not be limited to:

2 (A) the extension of the timely filing period;

3 (B) retroactive prior authorizations; and

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

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

10 (g-6) MCO Performance Metrics Report.

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

15 (A) claims payment, including timeliness and
16 accuracy;

17 (B) prior authorizations;

18 (C) grievance and appeals;

19 (D) utilization statistics;

20 (E) provider disputes;

21 (F) provider credentialing; and

22 (G) member and provider customer service.

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

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

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

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

7 (g-7) MCO claims processing and performance analysis. In
8 order to monitor MCO payments to hospital providers, pursuant
9 to this amendatory Act of the 100th General Assembly, the
10 Department shall post an analysis of MCO claims processing and
11 payment performance on its website every 6 months. Such
12 analysis shall include a review and evaluation of a
13 representative sample of hospital claims that are rejected and
14 denied for clean and unclean claims and the top 5 reasons for
15 such actions and timeliness of claims adjudication, which
16 identifies the percentage of claims adjudicated within 30, 60,
17 90, and over 90 days, and the dollar amounts associated with
18 those claims. The Department shall post the contracted claims
19 report required by HealthChoice Illinois on its website every 3
20 months.

21 (h) The Department shall not expand mandatory MCO
22 enrollment into new counties beyond those counties already
23 designated by the Department as of June 1, 2014 for the
24 individuals whose eligibility for medical assistance is not the
25 seniors or people with disabilities population until the
26 Department provides an opportunity for accountable care

1 entities and MCOs to participate in such newly designated
2 counties.

3 (i) The requirements of this Section apply to contracts
4 with accountable care entities and MCOs entered into, amended,
5 or renewed after June 16, 2014 (the effective date of Public
6 Act 98-651).

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

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