

SB2491



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

SB2491

Introduced 1/31/2018, by Sen. Dave Syverson

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

from Ch. 23, par. 5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that a licensed dental hygienist working under the supervision of a dentist and employed by a federally qualified health center shall be reimbursed for dental services provided to medical assistance recipients at the federally qualified health center's encounter rate. Effective immediately.

LRB100 17424 KTG 32592 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 Section 5-5 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 Notwithstanding any other provision of this Code and
2 subject to federal approval, the Department may adopt rules to
3 allow a dentist who is volunteering his or her service at no
4 cost to render dental services through an enrolled
5 not-for-profit health clinic without the dentist personally
6 enrolling as a participating provider in the medical assistance
7 program. A not-for-profit health clinic shall include a public
8 health clinic or Federally Qualified Health Center or other
9 enrolled provider, as determined by the Department, through
10 which dental services covered under this Section are performed.
11 The Department shall establish a process for payment of claims
12 for reimbursement for covered dental services rendered under
13 this provision.

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

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

24 The Illinois Department shall authorize the provision of,
25 and shall authorize payment for, screening by low-dose
26 mammography for the presence of occult breast cancer for women

1 35 years of age or older who are eligible for medical
2 assistance under this Article, as follows:

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

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

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

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

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

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

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

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

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

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

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

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

22 Subject to federal approval, the Department shall
23 establish a rate methodology for mammography at federally
24 qualified health centers and other encounter-rate clinics.
25 These clinics or centers may also collaborate with other
26 hospital-based mammography facilities. By January 1, 2016, the

1 Department shall report to the General Assembly on the status
2 of the provision set forth in this paragraph.

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

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

18 The Department shall devise a means of case-managing or
19 patient navigation for beneficiaries diagnosed with breast
20 cancer. This program shall initially operate as a pilot program
21 in areas of the State with the highest incidence of mortality
22 related to breast cancer. At least one pilot program site shall
23 be in the metropolitan Chicago area and at least one site shall
24 be outside the metropolitan Chicago area. On or after July 1,
25 2016, the pilot program shall be expanded to include one site
26 in western Illinois, one site in southern Illinois, one site in

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

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

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

26 All medical providers providing medical assistance to

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

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

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

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

1 procedures to the Illinois Department.

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

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

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

26 (2) The Department may elect to consider and negotiate

1 financial incentives to encourage the development of
2 Partnerships and the efficient delivery of medical care.

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

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

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

25 The Department shall apply for a waiver from the United
26 States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.

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

1 proof of receipt, unless the Illinois Department shall have put
2 into effect and shall be operating a system of post-payment
3 audit and review which shall, on a sampling basis, be deemed
4 adequate by the Illinois Department to assure that such drugs,
5 dentures, prosthetic devices and eyeglasses for which payment
6 is being made are actually being received by eligible
7 recipients. Within 90 days after September 16, 1984 (the
8 effective date of Public Act 83-1439), the Illinois Department
9 shall establish a current list of acquisition costs for all
10 prosthetic devices and any other items recognized as medical
11 equipment and supplies reimbursable under this Article and
12 shall update such list on a quarterly basis, except that the
13 acquisition costs of all prescription drugs shall be updated no
14 less frequently than every 30 days as required by Section
15 5-5.12.

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

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

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

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

1 for the Illinois Department.

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

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

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

26 The Department shall define or specify the following: (i)

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

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

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

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

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

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

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

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

1 are subject to receipt no later than 180 days after the
2 admission transaction has been completed.

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

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

21 The Illinois Department shall enter into agreements with
22 State agencies and departments, and is authorized to enter into
23 agreements with federal agencies and departments, under which
24 such agencies and departments shall share data necessary for
25 medical assistance program integrity functions and oversight.
26 The Illinois Department shall develop, in cooperation with

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

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

25 The Illinois Department shall establish policies,
26 procedures, standards and criteria by rule for the acquisition,

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

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

1 meet the accreditation requirement.

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

1 stakeholders representing the institutional and home and
2 community-based long term care interests. This Section shall
3 not restrict the Department from implementing lower level of
4 care eligibility criteria for community-based services in
5 circumstances where federal approval has been granted.

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

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

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

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

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

22 (d) efforts at utilization review and control by the
23 Illinois Department.

24 The period covered by each report shall be the 3 years
25 ending on the June 30 prior to the report. The report shall
26 include suggested legislation for consideration by the General

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

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

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

22 Because kidney transplantation can be an appropriate, cost
23 effective alternative to renal dialysis when medically
24 necessary and notwithstanding the provisions of Section 1-11 of
25 this Code, beginning October 1, 2014, the Department shall
26 cover kidney transplantation for noncitizens with end-stage

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

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

23 On or after July 1, 2015, opioid antagonists prescribed for
24 the treatment of an opioid overdose, including the medication
25 product, administration devices, and any pharmacy fees related
26 to the dispensing and administration of the opioid antagonist,

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

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

21 A dental hygienist, as defined under the Illinois Dental
22 Practice Act, working under the general supervision of a
23 dentist and employed by a federally qualified health center, as
24 defined in Section 1905(1)(2)(B) of the federal Social Security
25 Act, shall be reimbursed for dental services provided to
26 medical assistance recipients at the federally qualified

1 health center's encounter rate.

2 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
3 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
4 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;
5 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
6 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,
7 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
8 100-538, eff. 1-1-18; revised 10-26-17.)

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