Sen. John G. Mulroe

Filed: 3/2/2012

AMENDMENT TO SENATE BILL 2840

AMENDMENT NO. _____. Amend Senate Bill 2840 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Public Aid Code is amended by changing Sections 5-5, 11-13, 11-26, and 12-13.1 as follows:

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial

care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, for children and adults; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State, but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures

are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. The Illinois Department, by rule, shall prohibit any physician from providing medical assistance to anyone eligible therefor under this Code where such physician has been found guilty of performing an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

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

documentation.

The Department of Healthcare and Family Services shall provide the following services to persons eligible for assistance under this Article who are participating in education, training or employment programs operated by the Department of Human Services as successor to the Department of Public Aid:

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

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

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

The Illinois Department, by rule, may distinguish and

classify the medical services to be provided only in accordance with the classes of persons designated in Section 5-2.

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

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

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

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

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

(D) A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when medically

necessary as determined by a physician licensed to practice medicine in all of its branches.

All screenings shall include a physical breast exam, instruction on self-examination and information regarding the frequency of self-examination and its value as a preventative tool. For purposes of this Section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with an average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography.

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

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

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other hospital-based mammography facilities.

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

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

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. An evaluation of the pilot program shall be carried out measuring health outcomes and cost of care for those served by the pilot program compared to similarly situated patients who are not served by the pilot program.

Any medical or health care provider shall immediately recommend, to any pregnant woman who is being provided prenatal services and is suspected of drug abuse or is addicted as defined in the Alcoholism and Other Drug Abuse and Dependency Act, referral to a local substance abuse treatment provider

licensed by the Department of Human Services or to a licensed hospital which provides substance abuse treatment services. The Department of Healthcare and Family Services shall assure coverage for the cost of treatment of the drug abuse or addiction for pregnant recipients in accordance with the Illinois Medicaid Program in conjunction with the Department of Human Services.

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

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

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

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

Notwithstanding any other provision of law, a health care provider under the medical assistance program may elect, in lieu of receiving direct payment for services provided under that program, to participate in the State Employees Deferred Compensation Plan adopted under Article 24 of the Illinois Pension Code. A health care provider who elects to participate in the plan does not have a cause of action against the State for any damages allegedly suffered by the provider as a result of any delay by the State in crediting the amount of any contribution to the provider's plan account.

The Illinois Department may develop and contract with Partnerships of medical providers to arrange medical services for persons eligible under Section 5-2 of this Code. Implementation of this Section may be by demonstration projects in certain geographic areas. The Partnership shall be represented by a sponsor organization. The Department, by rule, shall develop qualifications for sponsors of Partnerships.

Nothing in this Section shall be construed to require that the sponsor organization be a medical organization.

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

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

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

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

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the

delivery of high quality medical services. These qualifications shall be determined by rule of the Illinois Department and may be higher than qualifications for participation in the medical assistance program. Partnership sponsors may prescribe reasonable additional qualifications for participation by medical providers, only with the prior written approval of the Illinois Department.

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

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period

then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after the effective date of this amendatory Act of 1984, the Illinois Department shall establish

a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

The rules and regulations of the Illinois Department shall require that a written statement including the required opinion of a physician shall accompany any claim for reimbursement for abortions, or induced miscarriages or premature births. This statement shall indicate what procedures were used in providing such medical services.

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

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

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

The Illinois Department shall have the authority to establish by rule the necessary procedures and policies to comply with the federal Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, and with subsequent federal statutes, rules, and regulations pertaining to Department functions.

Prior to enrollment in the medical assistance program, all vendors shall be subject to enhanced oversight, screening, and review based on categories of risk of fraud, waste, and abuse. The Illinois Department shall establish by rule the procedures for such screening and review.

Enrollment of a vendor ~~that provides non-emergency medical transportation, defined by the Department by rule,~~ shall be subject to a provisional period and shall be conditional for one year ~~180 days~~. During the period of conditional enrollment ~~that time~~, the Department ~~of Healthcare and Family Services~~ may terminate the vendor's eligibility to participate in, or may disenroll the vendor from, the medical assistance program without cause. Such ~~That~~ termination of eligibility or disenrollment is not subject to the Department's hearing process.

Prior to enrollment and during the conditional enrollment period, a vendor shall be subject to enhanced oversight based

on risk categories that may include, but are not limited to, criminal and financial background checks; fingerprinting; license, certification, and authorization verifications; unscheduled or unannounced site visits; database checks; prepayment audit reviews; audits; payment caps; payment suspensions; and other screening as required by federal or State law.

To be eligible for payment consideration, a provider's vendor-payment claim or bill, either as an initial or resubmitted claim following prior rejection, must be received by the Illinois Department, or its fiscal intermediary, no later than 90 days after the date on which medical goods or services were provided, with the following exception: the Illinois Department must receive a claim after disposition by Medicare or its fiscal intermediary no later than 24 months after the date on which medical goods or services were provided.

For claims for services rendered during a period for which a recipient received retroactive eligibility, claims must be filed within 90 days after the recipient was made eligible. For claims for which the Illinois Department is not the primary payer, claims must be submitted to the Illinois Department within 90 days after the final adjudication by the primary payer, but in no event more than 1 year after the date of service.

Claims that are not submitted and received in compliance

with the foregoing requirement shall not be eligible for payment under the medical assistance program, and the State shall have no liability for payment of those claims.

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

The Illinois Department shall enter into agreements with State and federal agencies and Departments under which such agencies shall share data necessary for program integrity functions and oversight. The Illinois Department shall develop, in cooperation with other State departments and agencies, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements

with State and federal agencies, including but not limited to, the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

Beginning in fiscal year 2013, the Illinois Department shall set forth a request for information to identify the benefits of a pre-payment, post-adjudication, and post-edit claims system with the goals of streamlining claims processing and provider reimbursement, reducing the number of pending or rejected claims, and helping to ensure a more transparent adjudication process through the utilization of: (i) provider data verification and provider screening technology; and (ii) clinical code editing. Such request for information shall not be considered as a request for proposal, or as an obligation on the part of the Illinois Department to take any action or acquire any products or services.

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients without medical authorization; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of the recipient's

needs, and the requirements and costs for maintaining such equipment. Such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department.

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped.

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

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

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

(b) actual statistics and trends in the provision of

the various medical services by medical vendors;

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

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

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

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

(Source: P.A. 96-156, eff. 1-1-10; 96-806, eff. 7-1-10; 96-926, eff. 1-1-11; 96-1000, eff. 7-2-10; 97-48, eff. 6-28-11; 97-638,

eff. 1-1-12.)

(305 ILCS 5/11-13) (from Ch. 23, par. 11-13)

Sec. 11-13. Conditions For Receipt of Vendor Payments - Limitation Period For Vendor Action - Penalty For Violation. A vendor payment, as defined in Section 2-5 of Article II, shall constitute payment in full for the goods or services covered thereby. Acceptance of the payment by or in behalf of the vendor shall bar him from obtaining, or attempting to obtain, additional payment therefor from the recipient or any other person. A vendor payment shall not, however, bar recovery of the value of goods and services the obligation for which, under the rules and regulations of the Illinois Department, is to be met from the income and resources available to the recipient, and in respect to which the vendor payment of the Illinois Department or the local governmental unit represents supplementation of such available income and resources.

Vendors seeking to enforce obligations of a governmental unit or the Illinois Department for goods or services (1) furnished to or in behalf of recipients and (2) subject to a vendor payment as defined in Section 2-5, shall commence their actions in the appropriate Circuit Court or the Court of Claims, as the case may require, within one year next after the cause of action accrued.

A cause of action accrues within the meaning of this Section upon the following date:

(1) If the vendor can prove that he submitted a bill for the service rendered to the Illinois Department or a governmental unit within 90 days after ~~12 months of~~ the date the service was rendered, then (a) upon the date the Illinois Department or a governmental unit mails to the vendor information that it is paying a bill in part or is refusing to pay a bill in whole or in part, or (b) upon the date one year following the date the vendor submitted such bill if the Illinois Department or a governmental unit fails to mail to the vendor such payment information within one year following the date the vendor submitted the bill; or

(2) If the vendor cannot prove that he submitted a bill for the service rendered within 90 days after ~~12 months of~~ the date the service was rendered, then upon the date 12 months following the date the vendor rendered the service to the recipient.

This paragraph governs only vendor payments as defined in this Code and as limited by regulations of the Illinois Department; it does not apply to goods or services purchased or contracted for by a recipient under circumstances in which the payment is to be made directly by the recipient.

Any vendor who accepts a vendor payment and who knowingly obtains or attempts to obtain additional payment for the goods or services covered by the vendor payment from the recipient or any other person shall be guilty of a Class B misdemeanor.

(Source: P.A. 86-430.)

(305 ILCS 5/11-26) (from Ch. 23, par. 11-26)

Sec. 11-26. Recipient's abuse of medical care; restrictions on access to medical care.

(a) When the Department determines, on the basis of statistical norms and medical judgment, that a medical care recipient has received medical services in excess of need and with such frequency or in such a manner as to constitute an abuse of the recipient's medical care privileges, the recipient's access to medical care may be restricted.

(b) When the Department has determined that a recipient is abusing his or her medical care privileges as described in this Section, it may require that the recipient designate a primary provider type of the recipient's own choosing to assume responsibility for the recipient's care. For the purposes of this subsection, "primary provider type" means a provider type as determined by the Department ~~primary care provider, primary care pharmacy, primary dentist, primary podiatrist, or primary durable medical equipment provider~~. Instead of requiring a recipient to make a designation as provided in this subsection, the Department, pursuant to rules adopted by the Department and without regard to any choice of an entity that the recipient might otherwise make, may initially designate a primary provider type provided that the primary provider type is willing to provide that care.

(c) When the Department has requested that a recipient

designate a primary provider type and the recipient fails or refuses to do so, the Department may, after a reasonable period of time, assign the recipient to a primary provider type of its own choice and determination, provided such primary provider type is willing to provide such care.

(d) When a recipient has been restricted to a designated primary provider type, the recipient may change the primary provider type:

(1) when the designated source becomes unavailable, as the Department shall determine by rule; or

(2) when the designated primary provider type notifies the Department that it wishes to withdraw from any obligation as primary provider type; or

(3) in other situations, as the Department shall provide by rule.

The Department shall, by rule, establish procedures for providing medical or pharmaceutical services when the designated source becomes unavailable or wishes to withdraw from any obligation as primary provider type, shall, by rule, take into consideration the need for emergency or temporary medical assistance and shall ensure that the recipient has continuous and unrestricted access to medical care from the date on which such unavailability or withdrawal becomes effective until such time as the recipient designates a primary provider type or a primary provider type willing to provide such care is designated by the Department consistent with

subsections (b) and (c) and such restriction becomes effective.

(e) Prior to initiating any action to restrict a recipient's access to medical or pharmaceutical care, the Department shall notify the recipient of its intended action. Such notification shall be in writing and shall set forth the reasons for and nature of the proposed action. In addition, the notification shall:

(1) inform the recipient that (i) the recipient has a right to designate a primary provider type of the recipient's own choosing willing to accept such designation and that the recipient's failure to do so within a reasonable time may result in such designation being made by the Department or (ii) the Department has designated a primary provider type to assume responsibility for the recipient's care; and

(2) inform the recipient that the recipient has a right to appeal the Department's determination to restrict the recipient's access to medical care and provide the recipient with an explanation of how such appeal is to be made. The notification shall also inform the recipient of the circumstances under which unrestricted medical eligibility shall continue until a decision is made on appeal and that if the recipient chooses to appeal, the recipient will be able to review the medical payment data that was utilized by the Department to decide that the recipient's access to medical care should be restricted.

(f) The Department shall, by rule or regulation, establish procedures for appealing a determination to restrict a recipient's access to medical care, which procedures shall, at a minimum, provide for a reasonable opportunity to be heard and, where the appeal is denied, for a written statement of the reason or reasons for such denial.

(g) Except as otherwise provided in this subsection, when a recipient has had his or her medical card restricted for 4 full quarters (without regard to any period of ineligibility for medical assistance under this Code, or any period for which the recipient voluntarily terminates his or her receipt of medical assistance, that may occur before the expiration of those 4 full quarters), the Department shall reevaluate the recipient's medical usage to determine whether it is still in excess of need and with such frequency or in such a manner as to constitute an abuse of the receipt of medical assistance. If it is still in excess of need, the restriction shall be continued for another 4 full quarters. If it is no longer in excess of need, the restriction shall be discontinued. If a recipient's access to medical care has been restricted under this Section and the Department then determines, either at reevaluation or after the restriction has been discontinued, to restrict the recipient's access to medical care a second or subsequent time, the second or subsequent restriction may be imposed for a period of more than 4 full quarters. If the Department restricts a recipient's access to medical care for a

period of more than 4 full quarters, as determined by rule, the Department shall reevaluate the recipient's medical usage after the end of the restriction period rather than after the end of 4 full quarters. The Department shall notify the recipient, in writing, of any decision to continue the restriction and the reason or reasons therefor. A "quarter", for purposes of this Section, shall be defined as one of the following 3-month periods of time: January-March, April-June, July-September or October-December.

(h) In addition to any other recipient whose acquisition of medical care is determined to be in excess of need, the Department may restrict the medical care privileges of the following persons:

(1) recipients found to have loaned or altered their cards or misused or falsely represented medical coverage;

(2) recipients found in possession of blank or forged prescription pads;

(3) recipients who knowingly assist providers in rendering excessive services or defrauding the medical assistance program.

The procedural safeguards in this Section shall apply to the above individuals.

(i) Restrictions under this Section shall be in addition to and shall not in any way be limited by or limit any actions taken under Article VIII-A of this Code.

(Source: P.A. 96-1501, eff. 1-25-11.)

(305 ILCS 5/12-13.1)

Sec. 12-13.1. Inspector General.

(a) The Governor shall appoint, and the Senate shall confirm, an Inspector General who shall function within the Illinois Department of Public Aid (now Healthcare and Family Services) and report to the Governor. The term of the Inspector General shall expire on the third Monday of January, 1997 and every 4 years thereafter.

(b) In order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct, the Inspector General shall oversee the Department of Healthcare and Family Services' integrity functions, which include, but are not limited to, the following:

(1) Investigation of misconduct by employees, vendors, contractors and medical providers, except for allegations of violations of the State Officials and Employees Ethics Act which shall be referred to the Office of the Governor's Executive Inspector General for investigation.

(2) Prepayment and post-payment audits ~~Audits~~ of medical providers related to ensuring that appropriate payments are made for services rendered and to the prevention and recovery of overpayments.

(3) Monitoring of quality assurance programs administered by the Department of Healthcare and Family Services ~~generally related to the medical assistance~~

~~program and specifically related to any managed care program~~.

(4) Quality control measurements of the programs administered by the Department of Healthcare and Family Services.

(5) Investigations of fraud or intentional program violations committed by clients of the Department of Healthcare and Family Services.

(6) Actions initiated against contractors, vendors, or medical providers for any of the following reasons:

(A) Violations of the medical assistance program.

(B) Sanctions against providers brought in conjunction with the Department of Public Health or the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities).

(C) Recoveries of assessments against hospitals and long-term care facilities.

(D) Sanctions mandated by the United States Department of Health and Human Services against medical providers.

(E) Violations of contracts related to any programs administered by the Department of Healthcare and Family Services ~~managed care programs~~.

(7) Representation of the Department of Healthcare and Family Services at hearings with the Illinois Department of

Financial and Professional Regulation in actions taken against professional licenses held by persons who are in violation of orders for child support payments.

(b-5) At the request of the Secretary of Human Services, the Inspector General shall, in relation to any function performed by the Department of Human Services as successor to the Department of Public Aid, exercise one or more of the powers provided under this Section as if those powers related to the Department of Human Services; in such matters, the Inspector General shall report his or her findings to the Secretary of Human Services.

(c) Notwithstanding, and in addition to, any other provision of law, the ~~The~~ Inspector General shall have access to all information, personnel and facilities of the Department of Healthcare and Family Services and the Department of Human Services (as successor to the Department of Public Aid), their employees, vendors, contractors and medical providers and any federal, State or local governmental agency that are necessary to perform the duties of the Office as directly related to public assistance programs administered by those departments. No medical provider shall be compelled, however, to provide individual medical records of patients who are not clients of the programs administered by the Department of Healthcare and Family Services ~~Medical Assistance Program~~. State and local governmental agencies are authorized and directed to provide the requested information, assistance or cooperation.

For purposes of enhanced program integrity functions and oversight, and to the extent consistent with applicable information, privacy, security, and disclosure laws, State and federal agencies shall provide the Inspector General access to confidential and other information and data. This includes, but is not limited to, information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

The Department of Healthcare and Family Services shall enter into agreements with State and federal agencies under which such agencies share data necessary for vendor screening, vendor review, and payment verification. The Department shall develop, in cooperation with other State and federal departments and agencies, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data necessary for vendor screening, vendor review, and payment verification. The Department shall enter into agreements with State and federal agencies, including but not limited to, the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial

and Professional Regulation.

The Inspector General shall have the authority to deny payment, prevent overpayments, and recover overpayments.

The Inspector General shall have the authority to deny or suspend payment to, and deny, terminate, or suspend the eligibility of, any vendor who fails to grant the Inspector General timely access to full and complete records in accordance with Section 140.28 of Title 89 of the Illinois Administrative Code, and other information for the purpose of audits, investigations, or other program integrity functions, after reasonable written request by the Inspector General.

The Inspector General shall have the authority to establish by rule the necessary procedures and policies to comply with the federal Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, and with subsequent federal statutes and rules pertaining to state program integrity requirements.

(d) The Inspector General shall serve as the Department of Healthcare and Family Services' primary liaison with law enforcement, investigatory and prosecutorial agencies, including but not limited to the following:

(1) The Department of State Police.

(2) The Federal Bureau of Investigation and other federal law enforcement agencies.

(3) The various Inspectors General of federal agencies overseeing the programs administered by the Department of

Healthcare and Family Services.

(4) The various Inspectors General of any other State agencies with responsibilities for portions of programs primarily administered by the Department of Healthcare and Family Services.

(5) The Offices of the several United States Attorneys in Illinois.

(6) The several State's Attorneys.

(7) The offices of the Centers for Medicare and Medicaid Services that administer the Medicare and Medicaid integrity programs.

The Inspector General shall meet on a regular basis with these entities to share information regarding possible misconduct by any persons or entities involved with the public aid programs administered by the Department of Healthcare and Family Services.

(e) All investigations conducted by the Inspector General shall be conducted in a manner that ensures the preservation of evidence for use in criminal prosecutions. If the Inspector General determines that a possible criminal act relating to fraud in the provision or administration of the medical assistance program has been committed, the Inspector General shall immediately notify the Medicaid Fraud Control Unit. If the Inspector General determines that a possible criminal act has been committed within the jurisdiction of the Office, the Inspector General may request the special expertise of the

Department of State Police. The Inspector General may present for prosecution the findings of any criminal investigation to the Office of the Attorney General, the Offices of the several United States Attorneys in Illinois or the several State's Attorneys.

(f) To carry out his or her duties as described in this Section, the Inspector General and his or her designees shall have the power to compel by subpoena the attendance and testimony of witnesses and the production of books, electronic records and papers as directly related to public assistance programs administered by the Department of Healthcare and Family Services or the Department of Human Services (as successor to the Department of Public Aid). No medical provider shall be compelled, however, to provide individual medical records of patients who are not clients of the Medical Assistance Program.

(g) The Inspector General shall report all convictions, terminations, and suspensions taken against vendors, contractors and medical providers to the Department of Healthcare and Family Services and to any agency responsible for licensing or regulating those persons or entities.

(h) The Inspector General shall make annual reports, findings, and recommendations regarding the Office's investigations into reports of fraud, waste, abuse, mismanagement, or misconduct relating to any ~~public aid~~ programs administered by the Department of Healthcare and

Family Services or the Department of Human Services (as successor to the Department of Public Aid) to the General Assembly and the Governor. These reports shall include, but not be limited to, the following information:

(1) Aggregate provider billing and payment information, including the number of providers at various Medicaid earning levels.

(2) The number of audits of the medical assistance program and the dollar savings resulting from those audits.

(3) The number of prescriptions rejected annually under the Department of Healthcare and Family Services' Refill Too Soon program and the dollar savings resulting from that program.

(4) Provider sanctions, in the aggregate, including terminations and suspensions.

(5) A detailed summary of the investigations undertaken in the previous fiscal year. These summaries shall comply with all laws and rules regarding maintaining confidentiality in the public aid programs.

(i) Nothing in this Section shall limit investigations by the Department of Healthcare and Family Services or the Department of Human Services that may otherwise be required by law or that may be necessary in their capacity as the central administrative authorities responsible for administration of their agency's ~~public aid~~ programs in this State.

(j) The Inspector General may issue shields or other

distinctive identification to his or her employees not exercising the powers of a peace officer if the Inspector General determines that a shield or distinctive identification is needed by an employee to carry out his or her responsibilities.

(Source: P.A. 95-331, eff. 8-21-07; 96-555, eff. 8-18-09; 96-1316, eff. 1-1-11.)

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