



101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB5068

Introduced 2/18/2020, by Rep. Norine K. Hammond

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 within 120 calendar days (rather than 45 calendar days) of receipt by a long-term care facility of required prescreening information, new admissions with associated admission documents shall be submitted through the Medical Electronic Data Interchange or the Recipient Eligibility Verification System or shall be submitted directly to the Department of Human Services using required admission forms.

LRB101 17974 KTG 67412 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 On and after July 1, 2018, the Department of Healthcare and
2 Family Services shall provide dental services to any adult who
3 is otherwise eligible for assistance under the medical
4 assistance program. As used in this paragraph, "dental
5 services" means diagnostic, preventative, restorative, or
6 corrective procedures, including procedures and services for
7 the prevention and treatment of periodontal disease and dental
8 caries disease, provided by an individual who is licensed to
9 practice dentistry or dental surgery or who is under the
10 supervision of a dentist in the practice of his or her
11 profession.

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

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

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

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

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

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

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

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

1 older.

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

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

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

15 (F) A diagnostic mammogram when medically necessary,
16 as determined by a physician licensed to practice medicine
17 in all its branches, advanced practice registered nurse, or
18 physician assistant.

19 The Department shall not impose a deductible, coinsurance,
20 copayment, or any other cost-sharing requirement on the
21 coverage provided under this paragraph; except that this
22 sentence does not apply to coverage of diagnostic mammograms to
23 the extent such coverage would disqualify a high-deductible
24 health plan from eligibility for a health savings account
25 pursuant to Section 223 of the Internal Revenue Code (26 U.S.C.
26 223).

1 All screenings shall include a physical breast exam,
2 instruction on self-examination and information regarding the
3 frequency of self-examination and its value as a preventative
4 tool.

5 For purposes of this Section:

6 "Diagnostic mammogram" means a mammogram obtained using
7 diagnostic mammography.

8 "Diagnostic mammography" means a method of screening that
9 is designed to evaluate an abnormality in a breast, including
10 an abnormality seen or suspected on a screening mammogram or a
11 subjective or objective abnormality otherwise detected in the
12 breast.

13 "Low-dose mammography" means the x-ray examination of the
14 breast using equipment dedicated specifically for mammography,
15 including the x-ray tube, filter, compression device, and image
16 receptor, with an average radiation exposure delivery of less
17 than one rad per breast for 2 views of an average size breast.
18 The term also includes digital mammography and includes breast
19 tomosynthesis.

20 "Breast tomosynthesis" means a radiologic procedure that
21 involves the acquisition of projection images over the
22 stationary breast to produce cross-sectional digital
23 three-dimensional images of the breast.

24 If, at any time, the Secretary of the United States
25 Department of Health and Human Services, or its successor
26 agency, promulgates rules or regulations to be published in the

1 Federal Register or publishes a comment in the Federal Register
2 or issues an opinion, guidance, or other action that would
3 require the State, pursuant to any provision of the Patient
4 Protection and Affordable Care Act (Public Law 111-148),
5 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
6 successor provision, to defray the cost of any coverage for
7 breast tomosynthesis outlined in this paragraph, then the
8 requirement that an insurer cover breast tomosynthesis is
9 inoperative other than any such coverage authorized under
10 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
11 the State shall not assume any obligation for the cost of
12 coverage for breast tomosynthesis set forth in this paragraph.

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

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

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

26 On and after January 1, 2017, providers participating in a

1 breast cancer treatment quality improvement program approved
2 by the Department shall be reimbursed for breast cancer
3 treatment at a rate that is no lower than 95% of the Medicare
4 program's rates for the data elements included in the breast
5 cancer treatment quality program.

6 The Department shall convene an expert panel, including
7 representatives of hospitals, free-standing breast cancer
8 treatment centers, breast cancer quality organizations, and
9 doctors, including breast surgeons, reconstructive breast
10 surgeons, oncologists, and primary care providers to establish
11 quality standards for breast cancer treatment.

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

19 The Department shall establish a methodology to remind
20 women who are age-appropriate for screening mammography, but
21 who have not received a mammogram within the previous 18
22 months, of the importance and benefit of screening mammography.
23 The Department shall work with experts in breast cancer
24 outreach and patient navigation to optimize these reminders and
25 shall establish a methodology for evaluating their
26 effectiveness and modifying the methodology based on the

1 evaluation.

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

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

22 The Department shall require all networks of care to
23 develop a means either internally or by contract with experts
24 in navigation and community outreach to navigate cancer
25 patients to comprehensive care in a timely fashion. The
26 Department shall require all networks of care to include access

1 for patients diagnosed with cancer to at least one academic
2 commission on cancer-accredited cancer program as an
3 in-network covered benefit.

4 Any medical or health care provider shall immediately
5 recommend, to any pregnant woman who is being provided prenatal
6 services and is suspected of having a substance use disorder as
7 defined in the Substance Use Disorder Act, referral to a local
8 substance use disorder treatment program licensed by the
9 Department of Human Services or to a licensed hospital which
10 provides substance abuse treatment services. The Department of
11 Healthcare and Family Services shall assure coverage for the
12 cost of treatment of the drug abuse or addiction for pregnant
13 recipients in accordance with the Illinois Medicaid Program in
14 conjunction with the Department of Human Services.

15 All medical providers providing medical assistance to
16 pregnant women under this Code shall receive information from
17 the Department on the availability of services under any
18 program providing case management services for addicted women,
19 including information on appropriate referrals for other
20 social services that may be needed by addicted women in
21 addition to treatment for addiction.

22 The Illinois Department, in cooperation with the
23 Departments of Human Services (as successor to the Department
24 of Alcoholism and Substance Abuse) and Public Health, through a
25 public awareness campaign, may provide information concerning
26 treatment for alcoholism and drug abuse and addiction, prenatal

1 health care, and other pertinent programs directed at reducing
2 the number of drug-affected infants born to recipients of
3 medical assistance.

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

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

16 The Illinois Department may develop and contract with
17 Partnerships of medical providers to arrange medical services
18 for persons eligible under Section 5-2 of this Code.
19 Implementation of this Section may be by demonstration projects
20 in certain geographic areas. The Partnership shall be
21 represented by a sponsor organization. The Department, by rule,
22 shall develop qualifications for sponsors of Partnerships.
23 Nothing in this Section shall be construed to require that the
24 sponsor organization be a medical organization.

25 The sponsor must negotiate formal written contracts with
26 medical providers for physician services, inpatient and

1 outpatient hospital care, home health services, treatment for
2 alcoholism and substance abuse, and other services determined
3 necessary by the Illinois Department by rule for delivery by
4 Partnerships. Physician services must include prenatal and
5 obstetrical care. The Illinois Department shall reimburse
6 medical services delivered by Partnership providers to clients
7 in target areas according to provisions of this Article and the
8 Illinois Health Finance Reform Act, except that:

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

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

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

21 Medical providers shall be required to meet certain
22 qualifications to participate in Partnerships to ensure the
23 delivery of high quality medical services. These
24 qualifications shall be determined by rule of the Illinois
25 Department and may be higher than qualifications for
26 participation in the medical assistance program. Partnership

1 sponsors may prescribe reasonable additional qualifications
2 for participation by medical providers, only with the prior
3 written approval of the Illinois Department.

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

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

16 The Illinois Department shall require health care
17 providers to maintain records that document the medical care
18 and services provided to recipients of Medical Assistance under
19 this Article. Such records must be retained for a period of not
20 less than 6 years from the date of service or as provided by
21 applicable State law, whichever period is longer, except that
22 if an audit is initiated within the required retention period
23 then the records must be retained until the audit is completed
24 and every exception is resolved. The Illinois Department shall
25 require health care providers to make available, when
26 authorized by the patient, in writing, the medical records in a

1 timely fashion to other health care providers who are treating
2 or serving persons eligible for Medical Assistance under this
3 Article. All dispensers of medical services shall be required
4 to maintain and retain business and professional records
5 sufficient to fully and accurately document the nature, scope,
6 details and receipt of the health care provided to persons
7 eligible for medical assistance under this Code, in accordance
8 with regulations promulgated by the Illinois Department. The
9 rules and regulations shall require that proof of the receipt
10 of prescription drugs, dentures, prosthetic devices and
11 eyeglasses by eligible persons under this Section accompany
12 each claim for reimbursement submitted by the dispenser of such
13 medical services. No such claims for reimbursement shall be
14 approved for payment by the Illinois Department without such
15 proof of receipt, unless the Illinois Department shall have put
16 into effect and shall be operating a system of post-payment
17 audit and review which shall, on a sampling basis, be deemed
18 adequate by the Illinois Department to assure that such drugs,
19 dentures, prosthetic devices and eyeglasses for which payment
20 is being made are actually being received by eligible
21 recipients. Within 90 days after September 16, 1984 (the
22 effective date of Public Act 83-1439), the Illinois Department
23 shall establish a current list of acquisition costs for all
24 prosthetic devices and any other items recognized as medical
25 equipment and supplies reimbursable under this Article and
26 shall update such list on a quarterly basis, except that the

1 acquisition costs of all prescription drugs shall be updated no
2 less frequently than every 30 days as required by Section
3 5-5.12.

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

15 Notwithstanding any other law to the contrary, the Illinois
16 Department shall, within 365 days after August 15, 2014 (the
17 effective date of Public Act 98-963), establish procedures to
18 permit ID/DD facilities licensed under the ID/DD Community Care
19 Act and MC/DD facilities licensed under the MC/DD Act to submit
20 monthly billing claims for reimbursement purposes. Following
21 development of these procedures, the Department shall have an
22 additional 365 days to test the viability of the new system and
23 to ensure that any necessary operational or structural changes
24 to its information technology platforms are implemented.

25 The Illinois Department shall require all dispensers of
26 medical services, other than an individual practitioner or

1 group of practitioners, desiring to participate in the Medical
2 Assistance program established under this Article to disclose
3 all financial, beneficial, ownership, equity, surety or other
4 interests in any and all firms, corporations, partnerships,
5 associations, business enterprises, joint ventures, agencies,
6 institutions or other legal entities providing any form of
7 health care services in this State under this Article.

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

16 Enrollment of a vendor shall be subject to a provisional
17 period and shall be conditional for one year. During the period
18 of conditional enrollment, the Department may terminate the
19 vendor's eligibility to participate in, or may disenroll the
20 vendor from, the medical assistance program without cause.
21 Unless otherwise specified, such termination of eligibility or
22 disenrollment is not subject to the Department's hearing
23 process. However, a disenrolled vendor may reapply without
24 penalty.

25 The Department has the discretion to limit the conditional
26 enrollment period for vendors based upon category of risk of

1 the vendor.

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

14 The Department shall define or specify the following: (i)
15 by provider notice, the "category of risk of the vendor" for
16 each type of vendor, which shall take into account the level of
17 screening applicable to a particular category of vendor under
18 federal law and regulations; (ii) by rule or provider notice,
19 the maximum length of the conditional enrollment period for
20 each category of risk of the vendor; and (iii) by rule, the
21 hearing rights, if any, afforded to a vendor in each category
22 of risk of the vendor that is terminated or disenrolled during
23 the conditional enrollment period.

24 To be eligible for payment consideration, a vendor's
25 payment claim or bill, either as an initial claim or as a
26 resubmitted claim following prior rejection, must be received

1 by the Illinois Department, or its fiscal intermediary, no
2 later than 180 days after the latest date on the claim on which
3 medical goods or services were provided, with the following
4 exceptions:

5 (1) In the case of a provider whose enrollment is in
6 process by the Illinois Department, the 180-day period
7 shall not begin until the date on the written notice from
8 the Illinois Department that the provider enrollment is
9 complete.

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

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

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

21 For claims for services rendered during a period for which
22 a recipient received retroactive eligibility, claims must be
23 filed within 180 days after the Department determines the
24 applicant is eligible. For claims for which the Illinois
25 Department is not the primary payer, claims must be submitted
26 to the Illinois Department within 180 days after the final

1 adjudication by the primary payer.

2 In the case of long term care facilities, within 120 ~~45~~
3 calendar days of receipt by the facility of required
4 prescreening information, new admissions with associated
5 admission documents shall be submitted through the Medical
6 Electronic Data Interchange (MEDI) or the Recipient
7 Eligibility Verification (REV) System or shall be submitted
8 directly to the Department of Human Services using required
9 admission forms. Effective September 1, 2014, admission
10 documents, including all prescreening information, must be
11 submitted through MEDI or REV. Confirmation numbers assigned to
12 an accepted transaction shall be retained by a facility to
13 verify timely submittal. Once an admission transaction has been
14 completed, all resubmitted claims following prior rejection
15 are subject to receipt no later than 180 days after the
16 admission transaction has been completed.

17 Claims that are not submitted and received in compliance
18 with the foregoing requirements shall not be eligible for
19 payment under the medical assistance program, and the State
20 shall have no liability for payment of those claims.

21 To the extent consistent with applicable information and
22 privacy, security, and disclosure laws, State and federal
23 agencies and departments shall provide the Illinois Department
24 access to confidential and other information and data necessary
25 to perform eligibility and payment verifications and other
26 Illinois Department functions. This includes, but is not

1 limited to: information pertaining to licensure;
2 certification; earnings; immigration status; citizenship; wage
3 reporting; unearned and earned income; pension income;
4 employment; supplemental security income; social security
5 numbers; National Provider Identifier (NPI) numbers; the
6 National Practitioner Data Bank (NPDB); program and agency
7 exclusions; taxpayer identification numbers; tax delinquency;
8 corporate information; and death records.

9 The Illinois Department shall enter into agreements with
10 State agencies and departments, and is authorized to enter into
11 agreements with federal agencies and departments, under which
12 such agencies and departments shall share data necessary for
13 medical assistance program integrity functions and oversight.
14 The Illinois Department shall develop, in cooperation with
15 other State departments and agencies, and in compliance with
16 applicable federal laws and regulations, appropriate and
17 effective methods to share such data. At a minimum, and to the
18 extent necessary to provide data sharing, the Illinois
19 Department shall enter into agreements with State agencies and
20 departments, and is authorized to enter into agreements with
21 federal agencies and departments, including, but not limited
22 to: the Secretary of State; the Department of Revenue; the
23 Department of Public Health; the Department of Human Services;
24 and the Department of Financial and Professional Regulation.

25 Beginning in fiscal year 2013, the Illinois Department
26 shall set forth a request for information to identify the

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

13 The Illinois Department shall establish policies,
14 procedures, standards and criteria by rule for the acquisition,
15 repair and replacement of orthotic and prosthetic devices and
16 durable medical equipment. Such rules shall provide, but not be
17 limited to, the following services: (1) immediate repair or
18 replacement of such devices by recipients; and (2) rental,
19 lease, purchase or lease-purchase of durable medical equipment
20 in a cost-effective manner, taking into consideration the
21 recipient's medical prognosis, the extent of the recipient's
22 needs, and the requirements and costs for maintaining such
23 equipment. Subject to prior approval, such rules shall enable a
24 recipient to temporarily acquire and use alternative or
25 substitute devices or equipment pending repairs or
26 replacements of any device or equipment previously authorized

1 for such recipient by the Department. Notwithstanding any
2 provision of Section 5-5f to the contrary, the Department may,
3 by rule, exempt certain replacement wheelchair parts from prior
4 approval and, for wheelchairs, wheelchair parts, wheelchair
5 accessories, and related seating and positioning items,
6 determine the wholesale price by methods other than actual
7 acquisition costs.

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

16 In order to promote environmental responsibility, meet the
17 needs of recipients and enrollees, and achieve significant cost
18 savings, the Department, or a managed care organization under
19 contract with the Department, may provide recipients or managed
20 care enrollees who have a prescription or Certificate of
21 Medical Necessity access to refurbished durable medical
22 equipment under this Section (excluding prosthetic and
23 orthotic devices as defined in the Orthotics, Prosthetics, and
24 Pedorthics Practice Act and complex rehabilitation technology
25 products and associated services) through the State's
26 assistive technology program's reutilization program, using

1 staff with the Assistive Technology Professional (ATP)
2 Certification if the refurbished durable medical equipment:
3 (i) is available; (ii) is less expensive, including shipping
4 costs, than new durable medical equipment of the same type;
5 (iii) is able to withstand at least 3 years of use; (iv) is
6 cleaned, disinfected, sterilized, and safe in accordance with
7 federal Food and Drug Administration regulations and guidance
8 governing the reprocessing of medical devices in health care
9 settings; and (v) equally meets the needs of the recipient or
10 enrollee. The reutilization program shall confirm that the
11 recipient or enrollee is not already in receipt of same or
12 similar equipment from another service provider, and that the
13 refurbished durable medical equipment equally meets the needs
14 of the recipient or enrollee. Nothing in this paragraph shall
15 be construed to limit recipient or enrollee choice to obtain
16 new durable medical equipment or place any additional prior
17 authorization conditions on enrollees of managed care
18 organizations.

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

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

23 The Illinois Department shall develop and operate, in
24 cooperation with other State Departments and agencies and in
25 compliance with applicable federal laws and regulations,
26 appropriate and effective systems of health care evaluation and

1 programs for monitoring of utilization of health care services
2 and facilities, as it affects persons eligible for medical
3 assistance under this Code.

4 The Illinois Department shall report annually to the
5 General Assembly, no later than the second Friday in April of
6 1979 and each year thereafter, in regard to:

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

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

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

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

15 The period covered by each report shall be the 3 years
16 ending on the June 30 prior to the report. The report shall
17 include suggested legislation for consideration by the General
18 Assembly. The requirement for reporting to the General Assembly
19 shall be satisfied by filing copies of the report as required
20 by Section 3.1 of the General Assembly Organization Act, and
21 filing such additional copies with the State Government Report
22 Distribution Center for the General Assembly as is required
23 under paragraph (t) of Section 7 of the State Library Act.

24 Rulemaking authority to implement Public Act 95-1045, if
25 any, is conditioned on the rules being adopted in accordance
26 with all provisions of the Illinois Administrative Procedure

1 Act and all rules and procedures of the Joint Committee on
2 Administrative Rules; any purported rule not so adopted, for
3 whatever reason, is unauthorized.

4 On and after July 1, 2012, the Department shall reduce any
5 rate of reimbursement for services or other payments or alter
6 any methodologies authorized by this Code to reduce any rate of
7 reimbursement for services or other payments in accordance with
8 Section 5-5e.

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

25 Notwithstanding any other provision of this Code to the
26 contrary, on or after July 1, 2015, all FDA approved forms of

1 medication assisted treatment prescribed for the treatment of
2 alcohol dependence or treatment of opioid dependence shall be
3 covered under both fee for service and managed care medical
4 assistance programs for persons who are otherwise eligible for
5 medical assistance under this Article and shall not be subject
6 to any (1) utilization control, other than those established
7 under the American Society of Addiction Medicine patient
8 placement criteria, (2) prior authorization mandate, or (3)
9 lifetime restriction limit mandate.

10 On or after July 1, 2015, opioid antagonists prescribed for
11 the treatment of an opioid overdose, including the medication
12 product, administration devices, and any pharmacy fees related
13 to the dispensing and administration of the opioid antagonist,
14 shall be covered under the medical assistance program for
15 persons who are otherwise eligible for medical assistance under
16 this Article. As used in this Section, "opioid antagonist"
17 means a drug that binds to opioid receptors and blocks or
18 inhibits the effect of opioids acting on those receptors,
19 including, but not limited to, naloxone hydrochloride or any
20 other similarly acting drug approved by the U.S. Food and Drug
21 Administration.

22 Upon federal approval, the Department shall provide
23 coverage and reimbursement for all drugs that are approved for
24 marketing by the federal Food and Drug Administration and that
25 are recommended by the federal Public Health Service or the
26 United States Centers for Disease Control and Prevention for

1 pre-exposure prophylaxis and related pre-exposure prophylaxis
2 services, including, but not limited to, HIV and sexually
3 transmitted infection screening, treatment for sexually
4 transmitted infections, medical monitoring, assorted labs, and
5 counseling to reduce the likelihood of HIV infection among
6 individuals who are not infected with HIV but who are at high
7 risk of HIV infection.

8 A federally qualified health center, as defined in Section
9 1905(1)(2)(B) of the federal Social Security Act, shall be
10 reimbursed by the Department in accordance with the federally
11 qualified health center's encounter rate for services provided
12 to medical assistance recipients that are performed by a dental
13 hygienist, as defined under the Illinois Dental Practice Act,
14 working under the general supervision of a dentist and employed
15 by a federally qualified health center.

16 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
17 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
18 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
19 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
20 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
21 1-1-20; revised 9-18-19.)