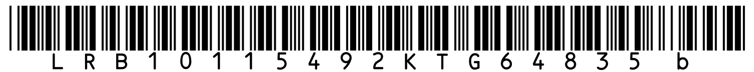
SB2520



101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB2520

Introduced 1/28/2020, by Sen. Omar Aquino

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 on and after July 1, 2020, the Department of Healthcare and Family Services shall administer a school-based dental program that allows for the out-of-office delivery of preventative dental services in a school setting to children under 19 years of age. Requires the Department to establish guidelines for participation by providers and set requirements for follow-up referral care based on each caries risk assessment code required for each student. Provides that every effort shall be made to ensure that children enrolled in the school-based dental program are assigned a primary dentist by allowing local dentists who practice within each school district the opportunity to participate in the school dental program prior to utilizing mobile dental services or dental providers outside the individual school boundaries. Provides that no provider shall be charged a fee by any unit of local government to participate in the school-based dental program administered by the Department. Effective immediately.

LRB101 15492 KTG 64835 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

laws of this State. 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, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical 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.

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department 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

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.

On and after July 1, 2020, the Department shall administer a school-based dental program that allows for the out-of-office delivery of preventative dental services in a school setting to children under 19 years of age. The Department shall establish guidelines for participation by providers and set requirements for follow-up referral care based on each caries risk assessment code required for each student.

Every effort shall be made to ensure that children enrolled in the school-based dental program are assigned a primary dentist by allowing local dentists who practice within each school district the opportunity to participate in the school dental program prior to utilizing mobile dental services or dental providers outside the individual school boundaries. No provider shall be charged a fee by any unit of local government to participate in the school-based dental program administered by the Department.

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 and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice

1 medicine in all of its branches.
2 (E) A screening MRI when medically necessary, as
3 determined by a physician licensed to practice medicine in
4 all of its branches.
5 (F) A diagnostic mammogram when medically necessary,
6 as determined by a physician licensed to practice medicine
7 in all its branches, advanced practice registered nurse, or
8 physician assistant.
9 The Department shall not impose a deductible, coinsurance,
10 copayment, or any other cost-sharing requirement on the
11 coverage provided under this paragraph; except that this
12 sentence does not apply to coverage of diagnostic mammograms to
13 the extent such coverage would disqualify a high-deductible
14 health plan from eligibility for a health savings account
15 pursuant to Section 223 of the Internal Revenue Code (26 U.S.C.
16 223).
17 All screenings shall include a physical breast exam,
18 instruction on self-examination and information regarding the
19 frequency of self-examination and its value as a preventative
20 tool.
21 For purposes of this Section:
22 "Diagnostic mammogram" means a mammogram obtained using
23 diagnostic mammography.
24 "Diagnostic mammography" means a method of screening that
25 is designed to evaluate an abnormality in a breast, including
26 an abnormality seen or suspected on a screening mammogram or a

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

1 the State shall not assume any obligation for the cost of
2 coverage for breast tomosynthesis set forth in this paragraph.
3 On and after January 1, 2016, the Department shall ensure
4 that all networks of care for adult clients of the Department
5 include access to at least one breast imaging Center of Imaging
6 Excellence as certified by the American College of Radiology.
7 On and after January 1, 2012, providers participating in a
8 quality improvement program approved by the Department shall be
9 reimbursed for screening and diagnostic mammography at the same
10 rate as the Medicare program's rates, including the increased
11 reimbursement for digital mammography.
12 The Department shall convene an expert panel including
13 representatives of hospitals, free-standing mammography
14 facilities, and doctors, including radiologists, to establish
15 quality standards for mammography.
16 On and after January 1, 2017, providers participating in a
17 breast cancer treatment quality improvement program approved
18 by the Department shall be reimbursed for breast cancer
19 treatment at a rate that is no lower than 95% of the Medicare
20 program's rates for the data elements included in the breast
21 cancer treatment quality program.
22 The Department shall convene an expert panel, including
23 representatives of hospitals, free-standing breast cancer
24 treatment centers, breast cancer quality organizations, and
25 doctors, including breast surgeons, reconstructive breast
26 surgeons, oncologists, and primary care providers to establish

quality standards for breast cancer treatment.

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. By January 1, 2016, the Department shall report to the General Assembly on the status of the provision set forth in this paragraph.

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

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

1 in areas of the State with the highest incidence of mortality
2 related to breast cancer. At least one pilot program site shall
3 be in the metropolitan Chicago area and at least one site shall
4 be outside the metropolitan Chicago area. On or after July 1,
5 2016, the pilot program shall be expanded to include one site
6 in western Illinois, one site in southern Illinois, one site in
7 central Illinois, and 4 sites within metropolitan Chicago. An
8 evaluation of the pilot program shall be carried out measuring
9 health outcomes and cost of care for those served by the pilot
10 program compared to similarly situated patients who are not
11 served by the pilot program.

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

20 Any medical or health care provider shall immediately
21 recommend, to any pregnant woman who is being provided prenatal
22 services and is suspected of having a substance use disorder as
23 defined in the Substance Use Disorder Act, referral to a local
24 substance use disorder treatment program licensed by the
25 Department of Human Services or to a licensed hospital which
26 provides substance abuse treatment services. The Department of

1 Healthcare and Family Services shall assure coverage for the
2 cost of treatment of the drug abuse or addiction for pregnant
3 recipients in accordance with the Illinois Medicaid Program in
4 conjunction with the Department of Human Services.

5 All medical providers providing medical assistance to
6 pregnant women under this Code shall receive information from
7 the Department on the availability of services under any
8 program providing case management services for addicted women,
9 including information on appropriate referrals for other
10 social services that may be needed by addicted women in
11 addition to treatment for addiction.

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

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

23 The Illinois Department shall establish such regulations
24 governing the dispensing of health services under this Article
25 as it shall deem appropriate. The Department should seek the
26 advice of formal professional advisory committees appointed by

1 the Director of the Illinois Department for the purpose of
2 providing regular advice on policy and administrative matters,
3 information dissemination and educational activities for
4 medical and health care providers, and consistency in
5 procedures to the Illinois Department.

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

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

25 (1) Physicians participating in a Partnership and
26 providing certain services, which shall be determined by

1 the Illinois Department, to persons in areas covered by the
2 Partnership may receive an additional surcharge for such
3 services.
4 (2) The Department may elect to consider and negotiate
5 financial incentives to encourage the development of
6 Partnerships and the efficient delivery of medical care.
7 (3) Persons receiving medical services through
8 Partnerships may receive medical and case management
9 services above the level usually offered through the
10 medical assistance program.
11 Medical providers shall be required to meet certain
12 qualifications to participate in Partnerships to ensure the
13 delivery of high quality medical services. These
14 qualifications shall be determined by rule of the Illinois
15 Department and may be higher than qualifications for
16 participation in the medical assistance program. Partnership
17 sponsors may prescribe reasonable additional qualifications
18 for participation by medical providers, only with the prior
19 written approval of the Illinois Department.
20 Nothing in this Section shall limit the free choice of
21 practitioners, hospitals, and other providers of medical
22 services by clients. In order to ensure patient freedom of
23 choice, the Illinois Department shall immediately promulgate
24 all rules and take all other necessary actions so that provided
25 services may be accessed from therapeutically certified
26 optometrists to the full extent of the Illinois Optometric

1 Practice Act of 1987 without discriminating between service
2 providers.
3 The Department shall apply for a waiver from the United
4 States Health Care Financing Administration to allow for the
5 implementation of Partnerships under this Section.
6 The Illinois Department shall require health care
7 providers to maintain records that document the medical care
8 and services provided to recipients of Medical Assistance under
9 this Article. Such records must be retained for a period of not
10 less than 6 years from the date of service or as provided by
11 applicable State law, whichever period is longer, except that
12 if an audit is initiated within the required retention period
13 then the records must be retained until the audit is completed
14 and every exception is resolved. The Illinois Department shall
15 require health care providers to make available, when
16 authorized by the patient, in writing, the medical records in a
17 timely fashion to other health care providers who are treating
18 or serving persons eligible for Medical Assistance under this
19 Article. All dispensers of medical services shall be required
20 to maintain and retain business and professional records
21 sufficient to fully and accurately document the nature, scope,
22 details and receipt of the health care provided to persons
23 eligible for medical assistance under this Code, in accordance
24 with regulations promulgated by the Illinois Department. The
25 rules and regulations shall require that proof of the receipt
26 of prescription drugs, dentures, prosthetic devices and

1 eyeglasses by eligible persons under this Section accompany
2 each claim for reimbursement submitted by the dispenser of such
3 medical services. No such claims for reimbursement shall be
4 approved for payment by the Illinois Department without such
5 proof of receipt, unless the Illinois Department shall have put
6 into effect and shall be operating a system of post-payment
7 audit and review which shall, on a sampling basis, be deemed
8 adequate by the Illinois Department to assure that such drugs,
9 dentures, prosthetic devices and eyeglasses for which payment
10 is being made are actually being received by eligible
11 recipients. Within 90 days after September 16, 1984 (the
12 effective date of Public Act 83-1439), the Illinois Department
13 shall establish a current list of acquisition costs for all
14 prosthetic devices and any other items recognized as medical
15 equipment and supplies reimbursable under this Article and
16 shall update such list on a quarterly basis, except that the
17 acquisition costs of all prescription drugs shall be updated no
18 less frequently than every 30 days as required by Section
19 5-5.12.

20 Notwithstanding any other law to the contrary, the Illinois
21 Department shall, within 365 days after July 22, 2013 (the
22 effective date of Public Act 98-104), establish procedures to
23 permit skilled care facilities licensed under the Nursing Home
24 Care Act to submit monthly billing claims for reimbursement
25 purposes. Following development of these procedures, the
26 Department shall, by July 1, 2016, test the viability of the

1 new system and implement any necessary operational or
2 structural changes to its information technology platforms in
3 order to allow for the direct acceptance and payment of nursing
4 home claims.

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

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

24 The Illinois Department may require that all dispensers of
25 medical services desiring to participate in the medical
26 assistance program established under this Article disclose,

1 under such terms and conditions as the Illinois Department may
2 by rule establish, all inquiries from clients and attorneys
3 regarding medical bills paid by the Illinois Department, which
4 inquiries could indicate potential existence of claims or liens
5 for the Illinois Department.

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

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

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

1 unannounced site visits; database checks; prepayment audit
2 reviews; audits; payment caps; payment suspensions; and other
3 screening as required by federal or State law.

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

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

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

26 (2) In the case of errors attributable to the Illinois

Department or any of its claims processing intermediaries which result in an inability to receive, process, or adjudicate a claim, the 180-day period shall not begin until the provider has been notified of the error.

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

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

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

In the case of long term care facilities, within 45 calendar days of receipt by the facility of required prescreening information, new admissions with associated admission documents shall be submitted through the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System or shall be submitted directly to the Department of Human Services using required admission forms. Effective September 1, 2014, admission documents, including all prescreening information, must be

1 submitted through MEDI or REV. Confirmation numbers assigned to
2 an accepted transaction shall be retained by a facility to
3 verify timely submittal. Once an admission transaction has been
4 completed, all resubmitted claims following prior rejection
5 are subject to receipt no later than 180 days after the
6 admission transaction has been completed.

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

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

25 The Illinois Department shall enter into agreements with
26 State agencies and departments, and is authorized to enter into

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

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

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

1 Medicaid Services and recognized by the Department in order to
2 bill the Department for providing durable medical equipment to
3 recipients. No later than 15 months after the effective date of
4 the rule adopted pursuant to this paragraph, all providers must
5 meet the accreditation requirement.

6 In order to promote environmental responsibility, meet the
7 needs of recipients and enrollees, and achieve significant cost
8 savings, the Department, or a managed care organization under
9 contract with the Department, may provide recipients or managed
10 care enrollees who have a prescription or Certificate of
11 Medical Necessity access to refurbished durable medical
12 equipment under this Section (excluding prosthetic and
13 orthotic devices as defined in the Orthotics, Prosthetics, and
14 Pedorthics Practice Act and complex rehabilitation technology
15 products and associated services) through the State's
16 assistive technology program's reutilization program, using
17 staff with the Assistive Technology Professional (ATP)
18 Certification if the refurbished durable medical equipment:
19 (i) is available; (ii) is less expensive, including shipping
20 costs, than new durable medical equipment of the same type;
21 (iii) is able to withstand at least 3 years of use; (iv) is
22 cleaned, disinfected, sterilized, and safe in accordance with
23 federal Food and Drug Administration regulations and guidance
24 governing the reprocessing of medical devices in health care
25 settings; and (v) equally meets the needs of the recipient or
26 enrollee. The reutilization program shall confirm that the

1 recipient or enrollee is not already in receipt of same or
2 similar equipment from another service provider, and that the
3 refurbished durable medical equipment equally meets the needs
4 of the recipient or enrollee. Nothing in this paragraph shall
5 be construed to limit recipient or enrollee choice to obtain
6 new durable medical equipment or place any additional prior
7 authorization conditions on enrollees of managed care
8 organizations.

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

community-based long term care; and (v) no later than October 1, 2013, establish procedures to permit long term care providers access to eligibility scores for individuals with an admission date who are seeking or receiving services from the long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

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;

1 (c) current rate structures and proposed changes in
2 those rate structures for the various medical vendors; and
3 (d) efforts at utilization review and control by the
4 Illinois Department.
5 The period covered by each report shall be the 3 years
6 ending on the June 30 prior to the report. The report shall
7 include suggested legislation for consideration by the General
8 Assembly. The requirement for reporting to the General Assembly
9 shall be satisfied by filing copies of the report as required
10 by Section 3.1 of the General Assembly Organization Act, and
11 filing such additional copies with the State Government Report
12 Distribution Center for the General Assembly as is required
13 under paragraph (t) of Section 7 of the State Library Act.
14 Rulemaking authority to implement Public Act 95-1045, if
15 any, is conditioned on the rules being adopted in accordance
16 with all provisions of the Illinois Administrative Procedure
17 Act and all rules and procedures of the Joint Committee on
18 Administrative Rules; any purported rule not so adopted, for
19 whatever reason, is unauthorized.
20 On and after July 1, 2012, the Department shall reduce any
21 rate of reimbursement for services or other payments or alter
22 any methodologies authorized by this Code to reduce any rate of
23 reimbursement for services or other payments in accordance with
24 Section 5-5e.
25 Because kidney transplantation can be an appropriate,
26 cost-effective alternative to renal dialysis when medically

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

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

26 On or after July 1, 2015, opioid antagonists prescribed for

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

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

24 A federally qualified health center, as defined in Section
25 1905(l)(2)(B) of the federal Social Security Act, shall be
26 reimbursed by the Department in accordance with the federally

1 qualified health center's encounter rate for services provided
2 to medical assistance recipients that are performed by a dental
3 hygienist, as defined under the Illinois Dental Practice Act,
4 working under the general supervision of a dentist and employed
5 by a federally qualified health center.
6 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
7 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
8 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
9 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
10 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
11 1-1-20; revised 9-18-19.)

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