

**SB3301**



**101ST GENERAL ASSEMBLY**

**State of Illinois**

**2019 and 2020**

**SB3301**

Introduced 2/11/2020, by Sen. Julie A. Morrison

**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 both individual and group tobacco cessation counseling shall be covered under the medical assistance program.

LRB101 18585 KTG 68040 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 Section, both  
13 individual and group tobacco cessation counseling shall be  
14 covered under the medical assistance program.

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

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

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

19           On and after July 1, 2012, the Department of Healthcare and  
20 Family Services may provide the following services to persons  
21 eligible for assistance under this Article who are  
22 participating in education, training or employment programs  
23 operated by the Department of Human Services as successor to  
24 the Department of Public Aid:

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

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

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

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

25          Notwithstanding any other provision of this Code and  
26          subject to federal approval, the Department may adopt rules to

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

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

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

22 The Illinois Department shall authorize the provision of,  
23 and shall authorize payment for, screening by low-dose  
24 mammography for the presence of occult breast cancer for women  
25 35 years of age or older who are eligible for medical  
26 assistance under this Article, as follows:

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

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

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

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

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

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

22 The Department shall not impose a deductible, coinsurance,  
23 copayment, or any other cost-sharing requirement on the  
24 coverage provided under this paragraph; except that this  
25 sentence does not apply to coverage of diagnostic mammograms to  
26 the extent such coverage would disqualify a high-deductible



1 health plan from eligibility for a health savings account  
2 pursuant to Section 223 of the Internal Revenue Code (26 U.S.C.  
3 223).

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

8 For purposes of this Section:

9 "Diagnostic mammogram" means a mammogram obtained using  
10 diagnostic mammography.

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

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

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

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

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

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

25           The Department shall convene an expert panel including  
26 representatives of hospitals, free-standing mammography

1 facilities, and doctors, including radiologists, to establish  
2 quality standards for mammography.

3 On and after January 1, 2017, providers participating in a  
4 breast cancer treatment quality improvement program approved  
5 by the Department shall be reimbursed for breast cancer  
6 treatment at a rate that is no lower than 95% of the Medicare  
7 program's rates for the data elements included in the breast  
8 cancer treatment quality program.

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

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

22 The Department shall establish a methodology to remind  
23 women who are age-appropriate for screening mammography, but  
24 who have not received a mammogram within the previous 18  
25 months, of the importance and benefit of screening mammography.  
26 The Department shall work with experts in breast cancer

1 outreach and patient navigation to optimize these reminders and  
2 shall establish a methodology for evaluating their  
3 effectiveness and modifying the methodology based on the  
4 evaluation.

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

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

25 The Department shall require all networks of care to  
26 develop a means either internally or by contract with experts

1 in navigation and community outreach to navigate cancer  
2 patients to comprehensive care in a timely fashion. The  
3 Department shall require all networks of care to include access  
4 for patients diagnosed with cancer to at least one academic  
5 commission on cancer-accredited cancer program as an  
6 in-network covered benefit.

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

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

25 The Illinois Department, in cooperation with the  
26 Departments of Human Services (as successor to the Department

1 of Alcoholism and Substance Abuse) and Public Health, through a  
2 public awareness campaign, may provide information concerning  
3 treatment for alcoholism and drug abuse and addiction, prenatal  
4 health care, and other pertinent programs directed at reducing  
5 the number of drug-affected infants born to recipients of  
6 medical assistance.

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

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

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

1 sponsor organization be a medical organization.

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

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

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

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

24 Medical providers shall be required to meet certain  
25 qualifications to participate in Partnerships to ensure the  
26 delivery of high quality medical services. These

1 qualifications shall be determined by rule of the Illinois  
2 Department and may be higher than qualifications for  
3 participation in the medical assistance program. Partnership  
4 sponsors may prescribe reasonable additional qualifications  
5 for participation by medical providers, only with the prior  
6 written approval of the Illinois Department.

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

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

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



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

1 prosthetic devices and any other items recognized as medical  
2 equipment and supplies reimbursable under this Article and  
3 shall update such list on a quarterly basis, except that the  
4 acquisition costs of all prescription drugs shall be updated no  
5 less frequently than every 30 days as required by Section  
6 5-5.12.

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

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

1 to its information technology platforms are implemented.

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

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

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

1 penalty.

2 The Department has the discretion to limit the conditional  
3 enrollment period for vendors based upon category of risk of  
4 the vendor.

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

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

1 To be eligible for payment consideration, a vendor's  
2 payment claim or bill, either as an initial claim or as a  
3 resubmitted claim following prior rejection, must be received  
4 by the Illinois Department, or its fiscal intermediary, no  
5 later than 180 days after the latest date on the claim on which  
6 medical goods or services were provided, with the following  
7 exceptions:

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

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

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

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

24 For claims for services rendered during a period for which  
25 a recipient received retroactive eligibility, claims must be  
26 filed within 180 days after the Department determines the

1 applicant is eligible. For claims for which the Illinois  
2 Department is not the primary payer, claims must be submitted  
3 to the Illinois Department within 180 days after the final  
4 adjudication by the primary payer.

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

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

24 To the extent consistent with applicable information and  
25 privacy, security, and disclosure laws, State and federal  
26 agencies and departments shall provide the Illinois Department

1 access to confidential and other information and data necessary  
2 to perform eligibility and payment verifications and other  
3 Illinois Department functions. This includes, but is not  
4 limited to: information pertaining to licensure;  
5 certification; earnings; immigration status; citizenship; wage  
6 reporting; unearned and earned income; pension income;  
7 employment; supplemental security income; social security  
8 numbers; National Provider Identifier (NPI) numbers; the  
9 National Practitioner Data Bank (NPDB); program and agency  
10 exclusions; taxpayer identification numbers; tax delinquency;  
11 corporate information; and death records.

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

1 and the Department of Financial and Professional Regulation.

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

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



1 recipient to temporarily acquire and use alternative or  
2 substitute devices or equipment pending repairs or  
3 replacements of any device or equipment previously authorized  
4 for such recipient by the Department. Notwithstanding any  
5 provision of Section 5-5f to the contrary, the Department may,  
6 by rule, exempt certain replacement wheelchair parts from prior  
7 approval and, for wheelchairs, wheelchair parts, wheelchair  
8 accessories, and related seating and positioning items,  
9 determine the wholesale price by methods other than actual  
10 acquisition costs.

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

19 In order to promote environmental responsibility, meet the  
20 needs of recipients and enrollees, and achieve significant cost  
21 savings, the Department, or a managed care organization under  
22 contract with the Department, may provide recipients or managed  
23 care enrollees who have a prescription or Certificate of  
24 Medical Necessity access to refurbished durable medical  
25 equipment under this Section (excluding prosthetic and  
26 orthotic devices as defined in the Orthotics, Prosthetics, and

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

22 The Department shall execute, relative to the nursing home  
23 prescreening project, written inter-agency agreements with the  
24 Department of Human Services and the Department on Aging, to  
25 effect the following: (i) intake procedures and common  
26 eligibility criteria for those persons who are receiving

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

26 The Illinois Department shall develop and operate, in

1 cooperation with other State Departments and agencies and in  
2 compliance with applicable federal laws and regulations,  
3 appropriate and effective systems of health care evaluation and  
4 programs for monitoring of utilization of health care services  
5 and facilities, as it affects persons eligible for medical  
6 assistance under this Code.

7 The Illinois Department shall report annually to the  
8 General Assembly, no later than the second Friday in April of  
9 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

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

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

1 kidney transplantation.

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

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

25 Upon federal approval, the Department shall provide  
26 coverage and reimbursement for all drugs that are approved for

1 marketing by the federal Food and Drug Administration and that  
2 are recommended by the federal Public Health Service or the  
3 United States Centers for Disease Control and Prevention for  
4 pre-exposure prophylaxis and related pre-exposure prophylaxis  
5 services, including, but not limited to, HIV and sexually  
6 transmitted infection screening, treatment for sexually  
7 transmitted infections, medical monitoring, assorted labs, and  
8 counseling to reduce the likelihood of HIV infection among  
9 individuals who are not infected with HIV but who are at high  
10 risk of HIV infection.

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

19 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;  
20 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.  
21 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,  
22 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;  
23 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.  
24 1-1-20; revised 9-18-19.)