

# HB0357



## 102ND GENERAL ASSEMBLY

### State of Illinois

2021 and 2022

HB0357

Introduced 1/29/2021, by Rep. Norine K. Hammond

#### SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

from Ch. 23, par. 5-5

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

LRB102 11639 KTG 16973 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  
16 home, or elsewhere; (6) medical care, or any other type of  
17 remedial care furnished by licensed practitioners; (7) home  
18 health care services; (8) private duty nursing service; (9)  
19 clinic services; (10) dental services, including prevention  
20 and treatment of periodontal disease and dental caries disease  
21 for pregnant women, provided by an individual licensed to  
22 practice dentistry or dental surgery; for purposes of this  
23 item (10), "dental services" means diagnostic, preventive, or

1 corrective procedures provided by or under the supervision of  
2 a dentist in the practice of his or her profession; (11)  
3 physical therapy and related services; (12) prescribed drugs,  
4 dentures, and prosthetic devices; and eyeglasses prescribed by  
5 a physician skilled in the diseases of the eye, or by an  
6 optometrist, whichever the person may select; (13) other  
7 diagnostic, screening, preventive, and rehabilitative  
8 services, including to ensure that the individual's need for  
9 intervention or treatment of mental disorders or substance use  
10 disorders or co-occurring mental health and substance use  
11 disorders is determined using a uniform screening, assessment,  
12 and 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  
22 sexual 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  
3 persons who rely on treatment by spiritual means alone through  
4 prayer for healing.

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

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

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

24 Upon receipt of federal approval of an amendment to the  
25 Illinois Title XIX State Plan for this purpose, the Department  
26 shall authorize the Chicago Public Schools (CPS) to procure a

1 vendor or vendors to manufacture eyeglasses for individuals  
2 enrolled in a school within the CPS system. CPS shall ensure  
3 that its vendor or vendors are enrolled as providers in the  
4 medical assistance program and in any capitated Medicaid  
5 managed care entity (MCE) serving individuals enrolled in a  
6 school within the CPS system. Under any contract procured  
7 under 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  
17 and Family Services may provide the following services to  
18 persons 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  
25 the diseases of the eye, or by an optometrist, whichever  
26 the person may select.

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

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

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

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

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

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

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

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

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

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

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

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

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



1 U.S.C. 223).

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

6 For purposes of this Section:

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

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

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

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

25 If, at any time, the Secretary of the United States  
26 Department of Health and Human Services, or its successor

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

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

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

1 cancer outreach and patient navigation to optimize these  
2 reminders and shall establish a methodology for evaluating  
3 their 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  
14 program in areas of the State with the highest incidence of  
15 mortality related to breast cancer. At least one pilot program  
16 site shall be in the metropolitan Chicago area and at least one  
17 site shall be outside the metropolitan Chicago area. On or  
18 after July 1, 2016, the pilot program shall be expanded to  
19 include one site in western Illinois, one site in southern  
20 Illinois, one site in central Illinois, and 4 sites within  
21 metropolitan Chicago. An evaluation of the pilot program shall  
22 be carried out measuring health outcomes and cost of care for  
23 those served by the pilot program compared to similarly  
24 situated patients who are not 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  
4 access for patients diagnosed with cancer to at least one  
5 academic 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  
9 prenatal services and is suspected of having a substance use  
10 disorder as defined in the Substance Use Disorder Act,  
11 referral to a local substance use disorder treatment program  
12 licensed by the Department of Human Services or to a licensed  
13 hospital which provides substance abuse treatment services.  
14 The Department of Healthcare and Family Services shall assure  
15 coverage for the cost of treatment of the drug abuse or  
16 addiction for pregnant recipients in accordance with the  
17 Illinois Medicaid Program in conjunction with the Department  
18 of Human Services.

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

26 The Illinois Department, in cooperation with the

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

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

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

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

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

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

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

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

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

26 Medical providers shall be required to meet certain

1 qualifications to participate in Partnerships to ensure the  
2 delivery of high quality medical services. These  
3 qualifications shall be determined by rule of the Illinois  
4 Department and may be higher than qualifications for  
5 participation in the medical assistance program. Partnership  
6 sponsors may prescribe reasonable additional qualifications  
7 for participation by medical providers, only with the prior  
8 written approval of the Illinois Department.

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

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

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



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

1 eligible recipients. Within 90 days after September 16, 1984  
2 (the effective date of Public Act 83-1439), the Illinois  
3 Department shall establish a current list of acquisition costs  
4 for all prosthetic devices and any other items recognized as  
5 medical equipment and supplies reimbursable under this Article  
6 and shall update such list on a quarterly basis, except that  
7 the acquisition costs of all prescription drugs shall be  
8 updated no less frequently than every 30 days as required by  
9 Section 5-5.12.

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

21 Notwithstanding any other law to the contrary, the  
22 Illinois Department shall, within 365 days after August 15,  
23 2014 (the effective date of Public Act 98-963), establish  
24 procedures to permit ID/DD facilities licensed under the ID/DD  
25 Community Care Act and MC/DD facilities licensed under the  
26 MC/DD Act to submit monthly billing claims for reimbursement

1 purposes. Following development of these procedures, the  
2 Department shall have an additional 365 days to test the  
3 viability of the new system and to ensure that any necessary  
4 operational or structural changes to its information  
5 technology platforms are implemented.

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

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

23 Enrollment of a vendor shall be subject to a provisional  
24 period and shall be conditional for one year. During the  
25 period of conditional enrollment, the Department may terminate  
26 the vendor's eligibility to participate in, or may disenroll

1 the vendor from, the medical assistance program without cause.  
2 Unless otherwise specified, such termination of eligibility or  
3 disenrollment is not subject to the Department's hearing  
4 process. However, a disenrolled vendor may reapply without  
5 penalty.

6 The Department has the discretion to limit the conditional  
7 enrollment period for vendors based upon category of risk of  
8 the vendor.

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

21 The Department shall define or specify the following: (i)  
22 by provider notice, the "category of risk of the vendor" for  
23 each type of vendor, which shall take into account the level of  
24 screening applicable to a particular category of vendor under  
25 federal law and regulations; (ii) by rule or provider notice,  
26 the maximum length of the conditional enrollment period for

1 each category of risk of the vendor; and (iii) by rule, the  
2 hearing rights, if any, afforded to a vendor in each category  
3 of risk of the vendor that is terminated or disenrolled during  
4 the conditional enrollment period.

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

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

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

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

24 (4) In the case of a provider operated by a unit of  
25 local government with a population exceeding 3,000,000  
26 when local government funds finance federal participation

1 for claims payments.

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

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

24 Claims that are not submitted and received in compliance  
25 with the foregoing requirements shall not be eligible for  
26 payment under the medical assistance program, and the State

1 shall have no liability for payment of those claims.

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

16 The Illinois Department shall enter into agreements with  
17 State agencies and departments, and is authorized to enter  
18 into agreements with federal agencies and departments, under  
19 which such agencies and departments shall share data necessary  
20 for medical assistance program integrity functions and  
21 oversight. The Illinois Department shall develop, in  
22 cooperation with other State departments and agencies, and in  
23 compliance with applicable federal laws and regulations,  
24 appropriate and effective methods to share such data. At a  
25 minimum, and to the extent necessary to provide data sharing,  
26 the Illinois Department shall enter into agreements with State

1 agencies and departments, and is authorized to enter into  
2 agreements with federal agencies and departments, including,  
3 but not limited to: the Secretary of State; the Department of  
4 Revenue; the Department of Public Health; the Department of  
5 Human Services; and the Department of Financial and  
6 Professional Regulation.

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

21 The Illinois Department shall establish policies,  
22 procedures, standards and criteria by rule for the  
23 acquisition, repair and replacement of orthotic and prosthetic  
24 devices and durable medical equipment. Such rules shall  
25 provide, but not be limited to, the following services: (1)  
26 immediate repair or replacement of such devices by recipients;



1 and (2) rental, lease, purchase or lease-purchase of durable  
2 medical equipment in a cost-effective manner, taking into  
3 consideration the recipient's medical prognosis, the extent of  
4 the recipient's needs, and the requirements and costs for  
5 maintaining such equipment. Subject to prior approval, such  
6 rules shall enable a recipient to temporarily acquire and use  
7 alternative or substitute devices or equipment pending repairs  
8 or replacements of any device or equipment previously  
9 authorized for such recipient by the Department.  
10 Notwithstanding any provision of Section 5-5f to the contrary,  
11 the Department may, by rule, exempt certain replacement  
12 wheelchair parts from prior approval and, for wheelchairs,  
13 wheelchair parts, wheelchair accessories, and related seating  
14 and positioning items, determine the wholesale price by  
15 methods other than actual acquisition costs.

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

24 In order to promote environmental responsibility, meet the  
25 needs of recipients and enrollees, and achieve significant  
26 cost savings, the Department, or a managed care organization

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

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

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

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

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

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

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

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

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

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

1 Assembly. The requirement for reporting to the General  
2 Assembly shall be satisfied by filing copies of the report as  
3 required by Section 3.1 of the General Assembly Organization  
4 Act, and filing such additional copies with the State  
5 Government Report Distribution Center for the General Assembly  
6 as is required under paragraph (t) of Section 7 of the State  
7 Library Act.

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

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

19 Because kidney transplantation can be an appropriate,  
20 cost-effective alternative to renal dialysis when medically  
21 necessary and notwithstanding the provisions of Section 1-11  
22 of this Code, beginning October 1, 2014, the Department shall  
23 cover kidney transplantation for noncitizens with end-stage  
24 renal disease who are not eligible for comprehensive medical  
25 benefits, who meet the residency requirements of Section 5-3  
26 of this Code, and who would otherwise meet the financial

1 requirements of the appropriate class of eligible persons  
2 under Section 5-2 of this Code. To qualify for coverage of  
3 kidney transplantation, such person must be receiving  
4 emergency renal dialysis services covered by the Department.  
5 Providers under this Section shall be prior approved and  
6 certified by the Department to perform kidney transplantation  
7 and the services under this Section shall be limited to  
8 services associated with kidney transplantation.

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

20 On or after July 1, 2015, opioid antagonists prescribed  
21 for the treatment of an opioid overdose, including the  
22 medication product, administration devices, and any pharmacy  
23 fees related to the dispensing and administration of the  
24 opioid antagonist, shall be covered under the medical  
25 assistance program for persons who are otherwise eligible for  
26 medical assistance under this Article. As used in this

1 Section, "opioid antagonist" means a drug that binds to opioid  
2 receptors and blocks or inhibits the effect of opioids acting  
3 on those receptors, including, but not limited to, naloxone  
4 hydrochloride or any other similarly acting drug approved by  
5 the U.S. Food and Drug Administration.

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

18 A federally qualified health center, as defined in Section  
19 1905(1)(2)(B) of the federal Social Security Act, shall be  
20 reimbursed by the Department in accordance with the federally  
21 qualified health center's encounter rate for services provided  
22 to medical assistance recipients that are performed by a  
23 dental hygienist, as defined under the Illinois Dental  
24 Practice Act, working under the general supervision of a  
25 dentist and employed by a federally qualified health center.

26 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;

1 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.  
2 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,  
3 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;  
4 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.  
5 1-1-20; revised 9-18-19.)