1 AN ACT concerning substance use disorders.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Substance Use Disorder Act is amended by
5 changing Sections 5-23 and 20-10 as follows:

6 (20 ILCS 301/5-23)
7 Sec. 5-23. Drug Overdose Prevention Program.
8 (a) Reports.
9 (1) The Department may publish annually a report on
10 drug overdose trends statewide that reviews State death
11 rates from available data to ascertain changes in the
12 causes or rates of fatal and nonfatal drug overdose. The
13 report shall also provide information on interventions
14 that would be effective in reducing the rate of fatal or
15 nonfatal drug overdose and on the current substance use
16 disorder treatment capacity within the State. The report
17 shall include an analysis of drug overdose information
18 reported to the Department of Public Health pursuant to
19 subsection (e) of Section 3-3013 of the Counties Code,
20 Section 6.14g of the Hospital Licensing Act, and
21 subsection (j) of Section 22-30 of the School Code.
22 (2) The report may include:
23 (A) Trends in drug overdose death rates.

1 (B) Trends in emergency room utilization related
2 to drug overdose and the cost impact of emergency room
3 utilization.
4 (C) Trends in utilization of pre-hospital and
5 emergency services and the cost impact of emergency
6 services utilization.
7 (D) Suggested improvements in data collection.
8 (E) A description of other interventions effective
9 in reducing the rate of fatal or nonfatal drug
10 overdose.
11 (F) A description of efforts undertaken to educate
12 the public about unused medication and about how to
13 properly dispose of unused medication, including the
14 number of registered collection receptacles in this
15 State, mail-back programs, and drug take-back events.
16 (G) An inventory of the State's substance use
17 disorder treatment capacity, including, but not
18 limited to:
19 (i) The number and type of licensed treatment
20 programs in each geographic area of the State.
21 (ii) The availability of medication-assisted
22 treatment at each licensed program and which types
23 of medication-assisted treatment are available.
24 (iii) The number of recovery homes that accept
25 individuals using medication-assisted treatment in
26 their recovery.

(iv) The number of medical professionals currently authorized to prescribe buprenorphine and the number of individuals who fill prescriptions for that medication at retail pharmacies as prescribed.

(v) Any partnerships between programs licensed by the Department and other providers of medication-assisted treatment.

(vi) Any challenges in providing medication-assisted treatment reported by programs licensed by the Department and any potential solutions.

(b) Programs; drug overdose prevention.

(1) The Department may establish a program to provide for the production and publication, in electronic and other formats, of drug overdose prevention, recognition, and response literature. The Department may develop and disseminate curricula for use by professionals, organizations, individuals, or committees interested in the prevention of fatal and nonfatal drug overdose, including, but not limited to, drug users, jail and prison personnel, jail and prison inmates, drug treatment professionals, emergency medical personnel, hospital staff, families and associates of drug users, peace officers, firefighters, public safety officers, needle exchange program staff, and other persons. In addition to

1 information regarding drug overdose prevention,
2 recognition, and response, literature produced by the
3 Department shall stress that drug use remains illegal and
4 highly dangerous and that complete abstinence from illegal
5 drug use is the healthiest choice. The literature shall
6 provide information and resources for substance use
7 disorder treatment.

8 The Department may establish or authorize programs for
9 prescribing, dispensing, or distributing opioid
10 antagonists for the treatment of drug overdose. Such
11 programs may include the prescribing of opioid antagonists
12 for the treatment of drug overdose to a person who is not
13 at risk of opioid overdose but who, in the judgment of the
14 health care professional, may be in a position to assist
15 another individual during an opioid-related drug overdose
16 and who has received basic instruction on how to
17 administer an opioid antagonist.

18 (2) The Department may provide advice to State and
19 local officials on the growing drug overdose crisis,
20 including the prevalence of drug overdose incidents,
21 programs promoting the disposal of unused prescription
22 drugs, trends in drug overdose incidents, and solutions to
23 the drug overdose crisis.

24 (3) The Department may support drug overdose
25 prevention, recognition, and response projects by
26 facilitating the acquisition of opioid antagonist

medication approved for opioid overdose reversal, facilitating the acquisition of opioid antagonist medication approved for opioid overdose reversal, providing trainings in overdose prevention best practices, connecting programs to medical resources, establishing a statewide standing order for the acquisition of needed medication, establishing learning collaboratives between localities and programs, and assisting programs in navigating any regulatory requirements for establishing or expanding such programs.

(4) In supporting best practices in drug overdose prevention programming, the Department may promote the following programmatic elements:

(A) Training individuals who currently use drugs in the administration of opioid antagonists approved for the reversal of an opioid overdose.

(B) Directly distributing opioid antagonists approved for the reversal of an opioid overdose rather than providing prescriptions to be filled at a pharmacy.

(C) Conducting street and community outreach to work directly with individuals who are using drugs.

(D) Employing community health workers or peer recovery specialists who are familiar with the communities served and can provide culturally competent services.

(E) Collaborating with other community-based organizations, substance use disorder treatment centers, or other health care providers engaged in treating individuals who are using drugs.

(F) Providing linkages for individuals to obtain evidence-based substance use disorder treatment.

(G) Engaging individuals exiting jails or prisons who are at a high risk of overdose.

(H) Providing education and training to community-based organizations who work directly with individuals who are using drugs and those individuals' families and communities.

(I) Providing education and training on drug overdose prevention and response to emergency personnel and law enforcement.

(J) Informing communities of the important role emergency personnel play in responding to accidental overdose.

(K) Producing and distributing targeted mass media materials on drug overdose prevention and response, the potential dangers of leaving unused prescription drugs in the home, and the proper methods for disposing of unused prescription drugs.

(c) Grants.

(1) The Department may award grants, in accordance with this subsection, to create or support local drug

overdose prevention, recognition, and response projects. Local health departments, correctional institutions, hospitals, universities, community-based organizations, and faith-based organizations may apply to the Department for a grant under this subsection at the time and in the manner the Department prescribes. Eligible grant activities include, but are not limited to, purchasing and distributing opioid antagonists, hiring peer recovery specialists or other community members to conduct community outreach, and hosting public health fairs or events to distribute opioid antagonists, promote harm reduction activities, and provide linkages to community partners.

(2) In awarding grants, the Department shall consider the overall rate of opioid overdose, the rate of increase in opioid overdose, and racial disparities in opioid overdose experienced by the communities to be served by grantees. The Department ~~necessity for overdose prevention projects in various settings and~~ shall encourage all grant applicants to develop interventions that will be effective and viable in their local areas.

(3) (Blank).

(3.5) Any hospital licensed under the Hospital Licensing Act or organized under the University of Illinois Hospital Act shall be deemed to have met the standards and requirements set forth in this Section to

1 enroll in the drug overdose prevention program upon
2 completion of the enrollment process except that proof of
3 a standing order and attestation of programmatic
4 requirements shall be waived for enrollment purposes.
5 Reporting mandated by enrollment shall be necessary to
6 carry out or attain eligibility for associated resources
7 under this Section for drug overdose prevention projects
8 operated on the licensed premises of the hospital and
9 operated by the hospital or its designated agent. The
10 Department shall streamline hospital enrollment for drug
11 overdose prevention programs by accepting such deemed
12 status under this Section in order to reduce barriers to
13 hospital participation in drug overdose prevention,
14 recognition, or response projects.
15 (4) In addition to moneys appropriated by the General
16 Assembly, the Department may seek grants from private
17 foundations, the federal government, and other sources to
18 fund the grants under this Section and to fund an
19 evaluation of the programs supported by the grants.
20 (d) Health care professional prescription of opioid
21 antagonists.
22 (1) A health care professional who, acting in good
23 faith, directly or by standing order, prescribes or
24 dispenses an opioid antagonist to: (a) a patient who, in
25 the judgment of the health care professional, is capable
26 of administering the drug in an emergency, or (b) a person

1 who is not at risk of opioid overdose but who, in the
2 judgment of the health care professional, may be in a
3 position to assist another individual during an
4 opioid-related drug overdose and who has received basic
5 instruction on how to administer an opioid antagonist
6 shall not, as a result of his or her acts or omissions, be
7 subject to: (i) any disciplinary or other adverse action
8 under the Medical Practice Act of 1987, the Physician
9 Assistant Practice Act of 1987, the Nurse Practice Act,
10 the Pharmacy Practice Act, or any other professional
11 licensing statute or (ii) any criminal liability, except
12 for willful and wanton misconduct.
13 (1.5) Notwithstanding any provision of or requirement
14 otherwise imposed by the Pharmacy Practice Act, the
15 Medical Practice Act of 1987, or any other law or rule,
16 including, but not limited to, any requirement related to
17 labeling, storage, or recordkeeping, a health care
18 professional or other person acting under the direction of
19 a health care professional may, directly or by standing
20 order, obtain, store, and dispense an opioid antagonist to
21 a patient in a facility that includes, but is not limited
22 to, a hospital, a hospital affiliate, or a federally
23 qualified health center if the patient information
24 specified in paragraph (4) of this subsection is provided
25 to the patient. A person acting in accordance with this
26 paragraph shall not, as a result of his or her acts or

omissions, be subject to: (i) any disciplinary or other adverse action under the Medical Practice Act of 1987, the Physician Assistant Practice Act of 1987, the Nurse Practice Act, the Pharmacy Practice Act, or any other professional licensing statute; or (ii) any criminal liability, except for willful and wanton misconduct.

(2) A person who is not otherwise licensed to administer an opioid antagonist may in an emergency administer without fee an opioid antagonist if the person has received the patient information specified in paragraph (4) of this subsection and believes in good faith that another person is experiencing a drug overdose. The person shall not, as a result of his or her acts or omissions, be (i) liable for any violation of the Medical Practice Act of 1987, the Physician Assistant Practice Act of 1987, the Nurse Practice Act, the Pharmacy Practice Act, or any other professional licensing statute, or (ii) subject to any criminal prosecution or civil liability, except for willful and wanton misconduct.

(3) A health care professional prescribing an opioid antagonist to a patient shall ensure that the patient receives the patient information specified in paragraph (4) of this subsection. Patient information may be provided by the health care professional or a community-based organization, substance use disorder program, or other organization with which the health care

1 professional establishes a written agreement that includes
2 a description of how the organization will provide patient
3 information, how employees or volunteers providing
4 information will be trained, and standards for documenting
5 the provision of patient information to patients.
6 Provision of patient information shall be documented in
7 the patient's medical record or through similar means as
8 determined by agreement between the health care
9 professional and the organization. The Department, in
10 consultation with statewide organizations representing
11 physicians, pharmacists, advanced practice registered
12 nurses, physician assistants, substance use disorder
13 programs, and other interested groups, shall develop and
14 disseminate to health care professionals, community-based
15 organizations, substance use disorder programs, and other
16 organizations training materials in video, electronic, or
17 other formats to facilitate the provision of such patient
18 information.
19 (4) For the purposes of this subsection:
20 "Opioid antagonist" means a drug that binds to opioid
21 receptors and blocks or inhibits the effect of opioids
22 acting on those receptors, including, but not limited to,
23 naloxone hydrochloride or any other similarly acting drug
24 approved by the U.S. Food and Drug Administration.
25 "Health care professional" means a physician licensed
26 to practice medicine in all its branches, a licensed

physician assistant with prescriptive authority, a licensed advanced practice registered nurse with prescriptive authority, an advanced practice registered nurse or physician assistant who practices in a hospital, hospital affiliate, or ambulatory surgical treatment center and possesses appropriate clinical privileges in accordance with the Nurse Practice Act, or a pharmacist licensed to practice pharmacy under the Pharmacy Practice Act.

"Patient" includes a person who is not at risk of opioid overdose but who, in the judgment of the physician, advanced practice registered nurse, or physician assistant, may be in a position to assist another individual during an overdose and who has received patient information as required in paragraph (2) of this subsection on the indications for and administration of an opioid antagonist.

"Patient information" includes information provided to the patient on drug overdose prevention and recognition; how to perform rescue breathing and resuscitation; opioid antagonist dosage and administration; the importance of calling 911; care for the overdose victim after administration of the overdose antagonist; and other issues as necessary.

(e) Drug overdose response policy.

(1) Every State and local government agency that

employs a law enforcement officer or fireman as those terms are defined in the Line of Duty Compensation Act must possess opioid antagonists and must establish a policy to control the acquisition, storage, transportation, and administration of such opioid antagonists and to provide training in the administration of opioid antagonists. A State or local government agency that employs a fireman as defined in the Line of Duty Compensation Act but does not respond to emergency medical calls or provide medical services shall be exempt from this subsection.

(2) Every publicly or privately owned ambulance, special emergency medical services vehicle, non-transport vehicle, or ambulance assist vehicle, as described in the Emergency Medical Services (EMS) Systems Act, that responds to requests for emergency services or transports patients between hospitals in emergency situations must possess opioid antagonists.

(3) Entities that are required under paragraphs (1) and (2) to possess opioid antagonists may also apply to the Department for a grant to fund the acquisition of opioid antagonists and training programs on the administration of opioid antagonists.

(Source: P.A. 100-201, eff. 8-18-17; 100-513, eff. 1-1-18; 100-759, eff. 1-1-19; 101-356, eff. 8-9-19.)

1 (20 ILCS 301/20-10)
2 Sec. 20-10. Screening, Brief Intervention, and Referral to
3 Treatment. As used in this Section, "SBIRT" means a
4 comprehensive, integrated, public health approach to the
5 delivery of early intervention and treatment services for
6 persons who are at risk of developing substance use disorders
7 or have substance use disorders including, but not limited to,
8 an addiction to alcohol, opioids, tobacco, or cannabis. SBIRT
9 services include all of the following:
10 (1) Screening to quickly assess the severity of
11 substance use and to identify the appropriate level of
12 treatment.
13 (2) Brief intervention focused on increasing insight
14 and awareness regarding substance use and motivation
15 toward behavioral change.
16 (3) Referral to treatment provided to those identified
17 as needing more extensive treatment with access to
18 specialty care.
19 SBIRT services may include, but are not limited to, the
20 following settings and programs: primary care centers,
21 hospital emergency rooms, hospital in-patient units, trauma
22 centers, community behavioral health programs, and other
23 community settings that provide opportunities for early
24 intervention with at-risk substance users before more severe
25 consequences occur.
26 ~~(a) As used in this Section, "SBIRT" means the~~

~~identification of individuals, within primary care settings, who need substance use disorder treatment. Primary care providers will screen and, based on the results of the screen, deliver a brief intervention or make referral to a licensed treatment provider as appropriate. SBIRT is not a licensed category of service.~~

~~(b) The Department may develop policy or best practice guidelines for identification of at-risk individuals through SBIRT and contract or billing requirements for SBIRT.~~

(Source: P.A. 100-759, eff. 1-1-19.)

Section 10. The Illinois Public Aid Code is amended by changing Section 5-5 and by adding Section 5-41 as follows:

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home

1 health care services; (8) private duty nursing service; (9)
2 clinic services; (10) dental services, including prevention
3 and treatment of periodontal disease and dental caries disease
4 for pregnant women, provided by an individual licensed to
5 practice dentistry or dental surgery; for purposes of this
6 item (10), "dental services" means diagnostic, preventive, or
7 corrective procedures provided by or under the supervision of
8 a dentist in the practice of his or her profession; (11)
9 physical therapy and related services; (12) prescribed drugs,
10 dentures, and prosthetic devices; and eyeglasses prescribed by
11 a physician skilled in the diseases of the eye, or by an
12 optometrist, whichever the person may select; (13) other
13 diagnostic, screening, preventive, and rehabilitative
14 services, including to ensure that the individual's need for
15 intervention or treatment of mental disorders or substance use
16 disorders or co-occurring mental health and substance use
17 disorders is determined using a uniform screening, assessment,
18 and evaluation process inclusive of criteria, for children and
19 adults; for purposes of this item (13), a uniform screening,
20 assessment, and evaluation process refers to a process that
21 includes an appropriate evaluation and, as warranted, a
22 referral; "uniform" does not mean the use of a singular
23 instrument, tool, or process that all must utilize; (14)
24 transportation and such other expenses as may be necessary;
25 (15) medical treatment of sexual assault survivors, as defined
26 in Section 1a of the Sexual Assault Survivors Emergency

1 Treatment Act, for injuries sustained as a result of the
2 sexual assault, including examinations and laboratory tests to
3 discover evidence which may be used in criminal proceedings
4 arising from the sexual assault; (16) the diagnosis and
5 treatment of sickle cell anemia; and (17) any other medical
6 care, and any other type of remedial care recognized under the
7 laws of this State. The term "any other type of remedial care"
8 shall include nursing care and nursing home service for
9 persons who rely on treatment by spiritual means alone through
10 prayer for healing.

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

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

23 Notwithstanding any other provision of this Code, the
24 Illinois Department may not require, as a condition of payment
25 for any laboratory test authorized under this Article, that a
26 physician's handwritten signature appear on the laboratory

1 test order form. The Illinois Department may, however, impose
2 other appropriate requirements regarding laboratory test order
3 documentation.

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

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

1 the Department of Public Aid:
2 (1) dental services provided by or under the
3 supervision of a dentist; and
4 (2) eyeglasses prescribed by a physician skilled in
5 the diseases of the eye, or by an optometrist, whichever
6 the person may select.
7 On and after July 1, 2018, the Department of Healthcare
8 and Family Services shall provide dental services to any adult
9 who is otherwise eligible for assistance under the medical
10 assistance program. As used in this paragraph, "dental
11 services" means diagnostic, preventative, restorative, or
12 corrective procedures, including procedures and services for
13 the prevention and treatment of periodontal disease and dental
14 caries disease, provided by an individual who is licensed to
15 practice dentistry or dental surgery or who is under the
16 supervision of a dentist in the practice of his or her
17 profession.
18 On and after July 1, 2018, targeted dental services, as
19 set forth in Exhibit D of the Consent Decree entered by the
20 United States District Court for the Northern District of
21 Illinois, Eastern Division, in the matter of Memisovski v.
22 Maram, Case No. 92 C 1982, that are provided to adults under
23 the medical assistance program shall be established at no less
24 than the rates set forth in the "New Rate" column in Exhibit D
25 of the Consent Decree for targeted dental services that are
26 provided to persons under the age of 18 under the medical

assistance program.

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

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

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

The Illinois Department shall authorize the provision of,

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

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

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

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

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

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

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

The Department shall not impose a deductible, coinsurance,

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

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

For purposes of this Section:

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

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

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

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

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

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

On and after January 1, 2012, providers participating in a

quality improvement program approved by the Department shall be reimbursed for screening and diagnostic mammography at the same rate as the Medicare program's rates, including the increased reimbursement for digital mammography.

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

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

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

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other hospital-based mammography facilities. By January 1, 2016, the Department shall report to the General Assembly on the status

of the provision set forth in this paragraph.

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

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

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. On or after July 1, 2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within

1 metropolitan Chicago. An evaluation of the pilot program shall
2 be carried out measuring health outcomes and cost of care for
3 those served by the pilot program compared to similarly
4 situated patients who are not served by the pilot program.

5 The Department shall require all networks of care to
6 develop a means either internally or by contract with experts
7 in navigation and community outreach to navigate cancer
8 patients to comprehensive care in a timely fashion. The
9 Department shall require all networks of care to include
10 access for patients diagnosed with cancer to at least one
11 academic commission on cancer-accredited cancer program as an
12 in-network covered benefit.

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

25 All medical providers providing medical assistance to
26 pregnant women under this Code shall receive information from

1 the Department on the availability of services under any
2 program providing case management services for addicted women,
3 including information on appropriate referrals for other
4 social services that may be needed by addicted women in
5 addition to treatment for addiction.

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

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

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

26 The Illinois Department may develop and contract with

Partnerships of medical providers to arrange medical services for persons eligible under Section 5-2 of this Code. Implementation of this Section may be by demonstration projects in certain geographic areas. The Partnership shall be represented by a sponsor organization. The Department, by rule, shall develop qualifications for sponsors of Partnerships. Nothing in this Section shall be construed to require that the sponsor organization be a medical organization.

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

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

(2) The Department may elect to consider and negotiate financial incentives to encourage the development of

Partnerships and the efficient delivery of medical care.

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

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

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

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

1 The Illinois Department shall require health care
2 providers to maintain records that document the medical care
3 and services provided to recipients of Medical Assistance
4 under this Article. Such records must be retained for a period
5 of not less than 6 years from the date of service or as
6 provided by applicable State law, whichever period is longer,
7 except that if an audit is initiated within the required
8 retention period then the records must be retained until the
9 audit is completed and every exception is resolved. The
10 Illinois Department shall require health care providers to
11 make available, when authorized by the patient, in writing,
12 the medical records in a timely fashion to other health care
13 providers who are treating or serving persons eligible for
14 Medical Assistance under this Article. All dispensers of
15 medical services shall be required to maintain and retain
16 business and professional records sufficient to fully and
17 accurately document the nature, scope, details and receipt of
18 the health care provided to persons eligible for medical
19 assistance under this Code, in accordance with regulations
20 promulgated by the Illinois Department. The rules and
21 regulations shall require that proof of the receipt of
22 prescription drugs, dentures, prosthetic devices and
23 eyeglasses by eligible persons under this Section accompany
24 each claim for reimbursement submitted by the dispenser of
25 such medical services. No such claims for reimbursement shall
26 be approved for payment by the Illinois Department without

such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after September 16, 1984 (the effective date of Public Act 83-1439), the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

1 Notwithstanding any other law to the contrary, the
2 Illinois Department shall, within 365 days after August 15,
3 2014 (the effective date of Public Act 98-963), establish
4 procedures to permit ID/DD facilities licensed under the ID/DD
5 Community Care Act and MC/DD facilities licensed under the
6 MC/DD Act to submit monthly billing claims for reimbursement
7 purposes. Following development of these procedures, the
8 Department shall have an additional 365 days to test the
9 viability of the new system and to ensure that any necessary
10 operational or structural changes to its information
11 technology platforms are implemented.

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

21 The Illinois Department may require that all dispensers of
22 medical services desiring to participate in the medical
23 assistance program established under this Article disclose,
24 under such terms and conditions as the Illinois Department may
25 by rule establish, all inquiries from clients and attorneys
26 regarding medical bills paid by the Illinois Department, which

inquiries could indicate potential existence of claims or liens for the Illinois Department.

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

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

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

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

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

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

23 (2) In the case of errors attributable to the Illinois
24 Department or any of its claims processing intermediaries
25 which result in an inability to receive, process, or
26 adjudicate a claim, the 180-day period shall not begin

until the provider has been notified of the error.

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

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

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

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

been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.

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

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

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and

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

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

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

22 The Department shall require, by rule, all providers of
23 durable medical equipment to be accredited by an accreditation
24 organization approved by the federal Centers for Medicare and
25 Medicaid Services and recognized by the Department in order to
26 bill the Department for providing durable medical equipment to

1 recipients. No later than 15 months after the effective date
2 of the rule adopted pursuant to this paragraph, all providers
3 must meet the accreditation requirement.

4 In order to promote environmental responsibility, meet the
5 needs of recipients and enrollees, and achieve significant
6 cost savings, the Department, or a managed care organization
7 under contract with the Department, may provide recipients or
8 managed care enrollees who have a prescription or Certificate
9 of Medical Necessity access to refurbished durable medical
10 equipment under this Section (excluding prosthetic and
11 orthotic devices as defined in the Orthotics, Prosthetics, and
12 Pedorthics Practice Act and complex rehabilitation technology
13 products and associated services) through the State's
14 assistive technology program's reutilization program, using
15 staff with the Assistive Technology Professional (ATP)
16 Certification if the refurbished durable medical equipment:
17 (i) is available; (ii) is less expensive, including shipping
18 costs, than new durable medical equipment of the same type;
19 (iii) is able to withstand at least 3 years of use; (iv) is
20 cleaned, disinfected, sterilized, and safe in accordance with
21 federal Food and Drug Administration regulations and guidance
22 governing the reprocessing of medical devices in health care
23 settings; and (v) equally meets the needs of the recipient or
24 enrollee. The reutilization program shall confirm that the
25 recipient or enrollee is not already in receipt of same or
26 similar equipment from another service provider, and that the

1 refurbished durable medical equipment equally meets the needs
2 of the recipient or enrollee. Nothing in this paragraph shall
3 be construed to limit recipient or enrollee choice to obtain
4 new durable medical equipment or place any additional prior
5 authorization conditions on enrollees of managed care
6 organizations.

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

permit long term care providers access to eligibility scores for individuals with an admission date who are seeking or receiving services from the long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

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

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

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

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

(c) current rate structures and proposed changes in

those rate structures for the various medical vendors; and

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

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

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

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

Because kidney transplantation can be an appropriate, cost-effective alternative to renal dialysis when medically

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

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

On or after July 1, 2015, opioid antagonists prescribed

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

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

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

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

(305 ILCS 5/5-41 new)

Sec. 5-41. Screening, Brief Intervention, and Referral to Treatment.

As used in this Section, "SBIRT" means a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons who are at risk of developing substance use disorders or have substance use disorders including, but not limited to, an addiction to alcohol, opioids, tobacco, or cannabis. SBIRT services include all of the following:

(1) Screening to quickly assess the severity of substance use and to identify the appropriate level of treatment.

(2) Brief intervention focused on increasing insight

1 and awareness regarding substance use and motivation
2 toward behavioral change.
3 (3) Referral to treatment provided to those identified
4 as needing more extensive treatment with access to
5 specialty care.
6 SBIRT services may include, but are not limited to, the
7 following settings and programs: primary care centers,
8 hospital emergency rooms, hospital in-patient units, trauma
9 centers, community behavioral health programs, and other
10 community settings that provide opportunities for early
11 intervention with at-risk substance users before more severe
12 consequences occur.
13 The Department of Healthcare and Family Services shall
14 develop and seek federal approval of a SBIRT benefit for which
15 qualified providers shall be reimbursed under the medical
16 assistance program.
17 In conjunction with the Department of Human Services'
18 Division of Substance Use Prevention and Recovery, the
19 Department of Healthcare and Family Services may develop a
20 methodology and reimbursement rate for SBIRT services provided
21 by qualified providers in approved settings.
22 For opioid specific SBIRT services provided in a hospital
23 emergency department, the Department of Healthcare and Family
24 Services shall develop a bundled reimbursement methodology and
25 rate for a package of opioid treatment services, which include
26 initiation of medication for the treatment of opioid use

1 disorder in the emergency department setting, including
2 assessment, referral to ongoing care, and arranging access to
3 supportive services when necessary. This package of opioid
4 related services shall be billed on a separate claim and shall
5 be reimbursed outside of the Enhanced Ambulatory Patient
6 Grouping system.