HB5739

LRB102 27071 KTG 38422 b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB5739

by Rep. Lakesia Collins

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 prosthetic wigs for persons diagnosed with a medical condition that causes hair loss, including, but not limited to, alopecia areata, shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance.

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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 individuals, provided by an individual licensed
22 to 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; (16.5) services performed by
26 a chiropractic physician licensed under the Medical Practice

1 Act of 1987 and acting within the scope of his or her license,
2 including, but not limited to, chiropractic manipulative
3 treatment; and (17) any other medical care, and any other type
4 of remedial care recognized under the laws of this State. The
5 term "any other type of remedial care" shall include nursing
6 care and nursing home service for persons who rely on
7 treatment by spiritual means alone through prayer for healing.

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

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

20 Notwithstanding any other provision of this Section, all
21 tobacco cessation medications approved by the United States
22 Food and Drug Administration and all individual and group
23 tobacco cessation counseling services and telephone-based
24 counseling services and tobacco cessation medications provided
25 through the Illinois Tobacco Quitline shall be covered under
26 the medical assistance program for persons who are otherwise

1 eligible for assistance under this Article. The Department
2 shall comply with all federal requirements necessary to obtain
3 federal financial participation, as specified in 42 CFR
4 433.15(b)(7), for telephone-based counseling services provided
5 through the Illinois Tobacco Quitline, including, but not
6 limited to: (i) entering into a memorandum of understanding or
7 interagency agreement with the Department of Public Health, as
8 administrator of the Illinois Tobacco Quitline; and (ii)
9 developing a cost allocation plan for Medicaid-allowable
10 Illinois Tobacco Quitline services in accordance with 45 CFR
11 95.507. The Department shall submit the memorandum of
12 understanding or interagency agreement, the cost allocation
13 plan, and all other necessary documentation to the Centers for
14 Medicare and Medicaid Services for review and approval.
15 Coverage under this paragraph shall be contingent upon federal
16 approval.

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.

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

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

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 On and after January 1, 2022, the Department of Healthcare
10 and Family Services shall administer and regulate a
11 school-based dental program that allows for the out-of-office
12 delivery of preventative dental services in a school setting
13 to children under 19 years of age. The Department shall
14 establish, by rule, guidelines for participation by providers
15 and set requirements for follow-up referral care based on the
16 requirements established in the Dental Office Reference Manual
17 published by the Department that establishes the requirements
18 for dentists participating in the All Kids Dental School
19 Program. Every effort shall be made by the Department when
20 developing the program requirements to consider the different
21 geographic differences of both urban and rural areas of the
22 State for initial treatment and necessary follow-up care. No
23 provider shall be charged a fee by any unit of local government
24 to participate in the school-based dental program administered
25 by the Department. Nothing in this paragraph shall be
26 construed to limit or preempt a home rule unit's or school

1 district's authority to establish, change, or administer a
2 school-based dental program in addition to, or independent of,
3 the school-based dental program administered by the
4 Department.

5 The Illinois Department, by rule, may distinguish and
6 classify the medical services to be provided only in
7 accordance with the classes of persons designated in Section
8 5-2.

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

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

21 (A) A baseline mammogram for individuals 35 to 39
22 years of age.

23 (B) An annual mammogram for individuals 40 years of
24 age or older.

25 (C) A mammogram at the age and intervals considered
26 medically necessary by the individual's health care

1 provider for individuals under 40 years of age and having
2 a family history of breast cancer, prior personal history
3 of breast cancer, positive genetic testing, or other risk
4 factors.

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

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

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

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

25 All screenings shall include a physical breast exam,
26 instruction on self-examination and information regarding the

1 frequency of self-examination and its value as a preventative
2 tool.
3 For purposes of this Section:
4 "Diagnostic mammogram" means a mammogram obtained using
5 diagnostic mammography.
6 "Diagnostic mammography" means a method of screening that
7 is designed to evaluate an abnormality in a breast, including
8 an abnormality seen or suspected on a screening mammogram or a
9 subjective or objective abnormality otherwise detected in the
10 breast.
11 "Low-dose mammography" means the x-ray examination of the
12 breast using equipment dedicated specifically for mammography,
13 including the x-ray tube, filter, compression device, and
14 image receptor, with an average radiation exposure delivery of
15 less than one rad per breast for 2 views of an average size
16 breast. The term also includes digital mammography and
17 includes breast tomosynthesis.
18 "Breast tomosynthesis" means a radiologic procedure that
19 involves the acquisition of projection images over the
20 stationary breast to produce cross-sectional digital
21 three-dimensional images of the breast.
22 If, at any time, the Secretary of the United States
23 Department of Health and Human Services, or its successor
24 agency, promulgates rules or regulations to be published in
25 the Federal Register or publishes a comment in the Federal
26 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

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

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

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

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

1 evaluation.

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

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

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

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

4 On or after July 1, 2022, individuals who are otherwise
5 eligible for medical assistance under this Article shall
6 receive coverage for perinatal depression screenings for the
7 12-month period beginning on the last day of their pregnancy.
8 Medical assistance coverage under this paragraph shall be
9 conditioned on the use of a screening instrument approved by
10 the Department.

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

23 All medical providers providing medical assistance to
24 pregnant individuals under this Code shall receive information
25 from the Department on the availability of services under any
26 program providing case management services for addicted

1 individuals, including information on appropriate referrals
2 for other social services that may be needed by addicted
3 individuals in addition to treatment for addiction.
4 The Illinois Department, in cooperation with the
5 Departments of Human Services (as successor to the Department
6 of Alcoholism and Substance Abuse) and Public Health, through
7 a public awareness campaign, may provide information
8 concerning treatment for alcoholism and drug abuse and
9 addiction, prenatal health care, and other pertinent programs
10 directed at reducing the number of drug-affected infants born
11 to recipients of medical assistance.
12 Neither the Department of Healthcare and Family Services
13 nor the Department of Human Services shall sanction the
14 recipient solely on the basis of the recipient's substance
15 abuse.
16 The Illinois Department shall establish such regulations
17 governing the dispensing of health services under this Article
18 as it shall deem appropriate. The Department should seek the
19 advice of formal professional advisory committees appointed by
20 the Director of the Illinois Department for the purpose of
21 providing regular advice on policy and administrative matters,
22 information dissemination and educational activities for
23 medical and health care providers, and consistency in
24 procedures to the Illinois Department.
25 The Illinois Department may develop and contract with
26 Partnerships of medical providers to arrange medical services

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

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

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

24 (2) The Department may elect to consider and negotiate
25 financial incentives to encourage the development of
26 Partnerships and the efficient delivery of medical care.

1 (3) Persons receiving medical services through
2 Partnerships may receive medical and case management
3 services above the level usually offered through the
4 medical assistance program.
5 Medical providers shall be required to meet certain
6 qualifications to participate in Partnerships to ensure the
7 delivery of high quality medical services. These
8 qualifications shall be determined by rule of the Illinois
9 Department and may be higher than qualifications for
10 participation in the medical assistance program. Partnership
11 sponsors may prescribe reasonable additional qualifications
12 for participation by medical providers, only with the prior
13 written approval of the Illinois Department.
14 Nothing in this Section shall limit the free choice of
15 practitioners, hospitals, and other providers of medical
16 services by clients. In order to ensure patient freedom of
17 choice, the Illinois Department shall immediately promulgate
18 all rules and take all other necessary actions so that
19 provided services may be accessed from therapeutically
20 certified optometrists to the full extent of the Illinois
21 Optometric Practice Act of 1987 without discriminating between
22 service providers.
23 The Department shall apply for a waiver from the United
24 States Health Care Financing Administration to allow for the
25 implementation of Partnerships under this Section.
26 The Illinois Department shall require health care

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

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

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

26 Notwithstanding any other law to the contrary, the

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

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

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

1 liens for the Illinois Department.

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

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

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

26 The Department shall define or specify the following: (i)

by provider notice, the "category of risk of the vendor" for each type of vendor, which shall take into account the level of screening applicable to a particular category of vendor under federal law and regulations; (ii) by rule or provider notice, the maximum length of the conditional enrollment period for each category of risk of the vendor; and (iii) by rule, the hearing rights, if any, afforded to a vendor in each category of risk of the vendor that is terminated or disenrolled during the conditional enrollment period.

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

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

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

1 (3) In the case of a provider for whom the Illinois
2 Department initiates the monthly billing process.
3 (4) In the case of a provider operated by a unit of
4 local government with a population exceeding 3,000,000
5 when local government funds finance federal participation
6 for claims payments.
7 For claims for services rendered during a period for which
8 a recipient received retroactive eligibility, claims must be
9 filed within 180 days after the Department determines the
10 applicant is eligible. For claims for which the Illinois
11 Department is not the primary payer, claims must be submitted
12 to the Illinois Department within 180 days after the final
13 adjudication by the primary payer.
14 In the case of long term care facilities, within 120
15 calendar days of receipt by the facility of required
16 prescreening information, new admissions with associated
17 admission documents shall be submitted through the Medical
18 Electronic Data Interchange (MEDI) or the Recipient
19 Eligibility Verification (REV) System or shall be submitted
20 directly to the Department of Human Services using required
21 admission forms. Effective September 1, 2014, admission
22 documents, including all prescreening information, must be
23 submitted through MEDI or REV. Confirmation numbers assigned
24 to an accepted transaction shall be retained by a facility to
25 verify timely submittal. Once an admission transaction has
26 been completed, all resubmitted claims following prior

1 rejection are subject to receipt no later than 180 days after
2 the admission transaction has been completed.

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

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

21 The Illinois Department shall enter into agreements with
22 State agencies and departments, and is authorized to enter
23 into agreements with federal agencies and departments, under
24 which such agencies and departments shall share data necessary
25 for medical assistance program integrity functions and
26 oversight. The Illinois Department shall develop, in

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

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

26 The Illinois Department shall establish policies,

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

21 The Department shall require, by rule, all providers of
22 durable medical equipment to be accredited by an accreditation
23 organization approved by the federal Centers for Medicare and
24 Medicaid Services and recognized by the Department in order to
25 bill the Department for providing durable medical equipment to
26 recipients. No later than 15 months after the effective date

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

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

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

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

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

18 The Illinois Department shall report annually to the
19 General Assembly, no later than the second Friday in April of
20 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

25 On or after July 1, 2015, opioid antagonists prescribed
26 for the treatment of an opioid overdose, including the

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

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

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

Within 90 days after October 8, 2021 (the effective date of Public Act 102-665) ~~this amendatory Act of the 102nd General Assembly~~, the Department shall seek federal approval of a State Plan amendment to expand coverage for family planning services that includes presumptive eligibility to individuals whose income is at or below 208% of the federal poverty level. Coverage under this Section shall be effective beginning no later than December 1, 2022.

Subject to approval by the federal Centers for Medicare and Medicaid Services of a Title XIX State Plan amendment electing the Program of All-Inclusive Care for the Elderly (PACE) as a State Medicaid option, as provided for by Subtitle I (commencing with Section 4801) of Title IV of the Balanced Budget Act of 1997 (Public Law 105-33) and Part 460 (commencing with Section 460.2) of Subchapter E of Title 42 of the Code of Federal Regulations, PACE program services shall become a covered benefit of the medical assistance program, subject to criteria established in accordance with all applicable laws.

Notwithstanding any other provision of this Code, community-based pediatric palliative care from a trained interdisciplinary team shall be covered under the medical

1 assistance program as provided in Section 15 of the Pediatric
2 Palliative Care Act.
3 Notwithstanding any other provision of this Code,
4 prosthetic wigs for persons diagnosed with a medical condition
5 that causes hair loss, including, but not limited to, alopecia
6 areata, shall be covered under the medical assistance program
7 for persons who are otherwise eligible for medical assistance
8 under this Article.
9 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;
10 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article
11 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section
12 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;
13 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.
14 1-1-22; 102-665, eff. 10-8-21; revised 11-18-21.)