



Sen. Ann Gillespie

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1 AMENDMENT TO SENATE BILL 1040

2 AMENDMENT NO. _____. Amend Senate Bill 1040 by replacing
3 everything after the enacting clause with the following:

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

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

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

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

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

24 Notwithstanding any other provision of this Code, the
25 Illinois Department may not require, as a condition of payment
26 for any laboratory test authorized under this Article, that a

1 physician's handwritten signature appear on the laboratory
2 test order form. The Illinois Department may, however, impose
3 other appropriate requirements regarding laboratory test order
4 documentation.

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

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

1 operated by the Department of Human Services as successor to
2 the Department of Public Aid:

3 (1) dental services provided by or under the
4 supervision of a dentist; and

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

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

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

1 provided to persons under the age of 18 under the medical
2 assistance program.

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

16 The Illinois Department, by rule, may distinguish and
17 classify the medical services to be provided only in
18 accordance with the classes of persons designated in Section
19 5-2.

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

1 The Illinois Department shall authorize the provision of,
2 and shall authorize payment for, screening by low-dose
3 mammography for the presence of occult breast cancer for women
4 35 years of age or older who are eligible for medical
5 assistance under this Article, as follows:

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

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

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

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

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

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

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

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

13 For purposes of this Section:

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

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

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

1 includes breast tomosynthesis.

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

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

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

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

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

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

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

22 Subject to federal approval, the Department shall
23 establish a rate methodology for mammography at federally
24 qualified health centers and other encounter-rate clinics.
25 These clinics or centers may also collaborate with other
26 hospital-based mammography facilities. By January 1, 2016, the

1 Department shall report to the General Assembly on the status
2 of the provision set forth in this paragraph.

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

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

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

1 Illinois, one site in central Illinois, and 4 sites within
2 metropolitan Chicago. An evaluation of the pilot program shall
3 be carried out measuring health outcomes and cost of care for
4 those served by the pilot program compared to similarly
5 situated patients who are not served by the pilot program.

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

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

26 All medical providers providing medical assistance to

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

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

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

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

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

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

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

26 (2) The Department may elect to consider and negotiate

1 financial incentives to encourage the development of
2 Partnerships and the efficient delivery of medical care.

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

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

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

25 The Department shall apply for a waiver from the United
26 States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.

2 The Illinois Department shall require health care
3 providers to maintain records that document the medical care
4 and services provided to recipients of Medical Assistance
5 under this Article. Such records must be retained for a period
6 of not less than 6 years from the date of service or as
7 provided by applicable State law, whichever period is longer,
8 except that if an audit is initiated within the required
9 retention period then the records must be retained until the
10 audit is completed and every exception is resolved. The
11 Illinois Department shall require health care providers to
12 make available, when authorized by the patient, in writing,
13 the medical records in a timely fashion to other health care
14 providers who are treating or serving persons eligible for
15 Medical Assistance under this Article. All dispensers of
16 medical services shall be required to maintain and retain
17 business and professional records sufficient to fully and
18 accurately document the nature, scope, details and receipt of
19 the health care provided to persons eligible for medical
20 assistance under this Code, in accordance with regulations
21 promulgated by the Illinois Department. The rules and
22 regulations shall require that proof of the receipt of
23 prescription drugs, dentures, prosthetic devices and
24 eyeglasses by eligible persons under this Section accompany
25 each claim for reimbursement submitted by the dispenser of
26 such medical services. No such claims for reimbursement shall

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

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

1 acceptance and payment of nursing home claims.

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

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

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

1 regarding medical bills paid by the Illinois Department, which
2 inquiries could indicate potential existence of claims or
3 liens for the Illinois Department.

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

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

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

1 screening as required by federal or State law.

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

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

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

24 (2) In the case of errors attributable to the Illinois
25 Department or any of its claims processing intermediaries
26 which result in an inability to receive, process, or

1 adjudicate a claim, the 180-day period shall not begin
2 until the provider has been notified of the error.

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

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

9 (5) In cases established by Department rule.

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

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

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

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

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

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

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

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

1 or as an obligation on the part of the Illinois Department to
2 take any action or acquire any products or services.

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

24 The Department shall require, by rule, all providers of
25 durable medical equipment to be accredited by an accreditation
26 organization approved by the federal Centers for Medicare and

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

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

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

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

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

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

21 The Illinois Department shall report annually to the
22 General Assembly, no later than the second Friday in April of
23 1979 and each year thereafter, in regard to:

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

26 (b) actual statistics and trends in the provision of

1 the various medical services by medical vendors;

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

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

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

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

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

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

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

1 lifetime restriction limit mandate.

2 On or after July 1, 2015, opioid antagonists prescribed
3 for the treatment of an opioid overdose, including the
4 medication product, administration devices, and any pharmacy
5 fees related to the dispensing and administration of the
6 opioid antagonist, shall be covered under the medical
7 assistance program for persons who are otherwise eligible for
8 medical assistance under this Article. As used in this
9 Section, "opioid antagonist" means a drug that binds to opioid
10 receptors and blocks or inhibits the effect of opioids acting
11 on those receptors, including, but not limited to, naloxone
12 hydrochloride or any other similarly acting drug approved by
13 the U.S. Food and Drug Administration.

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

26 A federally qualified health center, as defined in Section

1 1905(1)(2)(B) of the federal Social Security Act, shall be
2 reimbursed by the Department in accordance with the federally
3 qualified health center's encounter rate for services provided
4 to medical assistance recipients that are performed by a
5 dental hygienist, as defined under the Illinois Dental
6 Practice Act, working under the general supervision of a
7 dentist and employed by a federally qualified health center.

8 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
9 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
10 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
11 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
12 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
13 1-1-20; revised 9-18-19.)

14 Section 99. Effective date. This Act takes effect upon
15 becoming law."