AN ACT concerning regulation.

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

Article 3.

Section 3-1. Short title. This Act may be cited as the Illinois Certified Community Behavioral Health Clinics Act.

Section 3-5. Certified Community Behavioral Health Clinic program. The Department of Healthcare and Family Services, in collaboration with the Department of Human Services and with meaningful input from customers and key behavioral health stakeholders, shall develop a Comprehensive Statewide Behavioral Health Strategy and shall submit this Strategy to the Governor and General Assembly no later than July 1, 2022. The Strategy shall address key components of current and past legislation as well as current initiatives related to behavioral health services in order to develop a cohesive behavioral health system that reduces the administrative burden for customers and providers and includes: (i) comprehensive home and community-based services; (ii) integrated mental health, substance use disorder, and physical health services, and social determinants of health; and (iii) innovative payment models that support providers in offering

integrated services that are clinically effective and fiscally supported. The Strategy shall consolidate required pilots and initiatives into a cohesive behavioral health system designed to serve both adults and children in the least restrictive setting, as early as possible, once behavioral health needs have been identified, and through evidence-informed practices identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and other national experts. The Strategy shall take into consideration initiatives such as the Healthcare Transformation Collaboratives program; integrated health homes; services offered under federal Medicaid waiver authorities, including Sections 1915(i) and 1115 of the Social Security Act; requirements for certified community behavioral health centers; enhanced team-based services; housing and employment supports; and other initiatives identified by customers and stakeholders. The Strategy shall also identify the proper capacity for residential and institutional services while emphasizing serving customers in the community.

As part of the Strategy development process, by January 1, 2022 the Department of Healthcare and Family Services shall establish a program for the implementation of certified community behavioral health clinics. Behavioral health services providers that received federal grant funding from SAMHSA for the implementation of certified community behavioral health clinics prior to July 1, 2021 shall be eligible to participate in the program established in

accordance with this Section.

Article 5.

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

(305 ILCS 5/5-5f)

Sec. 5-5f. Elimination and limitations of medical assistance services. Notwithstanding any other provision of this Code to the contrary, on and after July 1, 2012:

(a) The following services shall no longer be a covered service available under this Code: group psychotherapy for residents of any facility licensed under the Nursing Home Care Act or the Specialized Mental Health Rehabilitation Act of 2013; and adult chiropractic services.

(b) The Department shall place the following limitations on services: (i) the Department shall limit adult eyeglasses to one pair every 2 years; however, the limitation does not apply to an individual who needs different eyeglasses following a surgical procedure such as cataract surgery; (ii) the Department shall set an annual limit of a maximum of 20 visits for each of the following services: adult speech, hearing, and language therapy services, adult occupational therapy services, and

physical therapy services; on or after October 1, 2014, the annual maximum limit of 20 visits shall expire but the Department may require prior approval for all individuals for speech, hearing, and language therapy services, occupational therapy services, and physical therapy services; (iii) the Department shall limit adult podiatry services to individuals with diabetes; on or after October 1, 2014, podiatry services shall not be limited to individuals with diabetes; (iv) the Department shall pay for caesarean sections at the normal vaginal delivery rate unless a caesarean section was medically necessary; (v) the Department shall limit adult dental services to emergencies; beginning July 1, 2013, the Department shall ensure that the following conditions are recognized as emergencies: (A) dental services necessary for an individual in order for the individual to be cleared for a medical procedure, such as a transplant; (B) extractions and dentures necessary for a diabetic to receive proper nutrition; (C) extractions and dentures necessary as a result of cancer treatment; and (D) dental services necessary for the health of a pregnant woman prior to delivery of her baby; on or after July 1, 2014, adult dental services shall no longer be limited to emergencies, and dental services necessary for the health of a pregnant woman prior to delivery of her baby shall continue to be covered; and (vi) effective July 1, 2012 <u>through June 30,</u>

2021, the Department shall place limitations and require concurrent review on every inpatient detoxification stay to prevent repeat admissions to any hospital for detoxification within 60 days of a previous inpatient detoxification stay. The Department shall convene a workgroup of hospitals, substance abuse providers, care coordination entities, managed care plans, and other stakeholders to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification, which shall be published on the Department's website no later than September 1, 2013.

(c) The Department shall require prior approval of the following services: wheelchair repairs costing more than $400, coronary artery bypass graft, and bariatric surgery consistent with Medicare standards concerning patient responsibility. Wheelchair repair prior approval requests shall be adjudicated within one business day of receipt of complete supporting documentation. Providers may not break wheelchair repairs into separate claims for purposes of staying under the $400 threshold for requiring prior approval. The wholesale price of manual and power wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

(d) The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a minimum, $40,000,000.

(e) The Department shall establish utilization controls for the hospice program such that it shall not pay for other care services when an individual is in hospice.

(f) For home health services, the Department shall require Medicare certification of providers participating in the program and implement the Medicare face-to-face encounter rule. The Department shall require providers to implement auditable electronic service verification based on global positioning systems or other cost-effective technology.

(g) For the Home Services Program operated by the Department of Human Services and the Community Care Program operated by the Department on Aging, the Department of Human Services, in cooperation with the Department on Aging, shall implement an electronic service verification based on global positioning systems or other cost-effective technology.

(h) Effective with inpatient hospital admissions on or after July 1, 2012, the Department shall reduce the payment for a claim that indicates the occurrence of a provider-preventable condition during the admission as specified by the Department in rules. The Department shall not pay for services related to an other provider-preventable condition.

As used in this subsection (h):

"Provider-preventable condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 or an other provider-preventable condition.

"Other provider-preventable condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

(i) The Department shall implement cost savings initiatives for advanced imaging services, cardiac imaging

services, pain management services, and back surgery. Such initiatives shall be designed to achieve annual costs savings.

(j) The Department shall ensure that beneficiaries with a diagnosis of epilepsy or seizure disorder in Department records will not require prior approval for anticonvulsants.

(Source: P.A. 100-135, eff. 8-18-17; 101-209, eff. 8-5-19.)

(305 ILCS 5/5-41 new)

Sec. 5-41. Inpatient hospitalization for opioid-related overdose or withdrawal patients. Due to the disproportionately high opioid-related fatality rates among African Americans in under-resourced communities in Illinois, the lack of community resources, the comorbidities experienced by these patients, and the high rate of hospital inpatient recidivism associated with this population when improperly treated, the Department shall ensure that patients, whether enrolled under the Medical Assistance Fee For Service program or enrolled with a Medicaid Managed Care Organization, experiencing opioid-related overdose or withdrawal are admitted on an inpatient status and the provider shall be reimbursed accordingly, when deemed medically necessary, as determined by either the patient's primary care physician, or the physician or other practitioner responsible for the patient's care at the hospital to which the patient presents, using criteria established by the

American Society of Addiction Medicine. If it is determined by the physician or other practitioner responsible for the patient's care at the hospital to which the patient presents, that a patient does not meet medical necessity criteria for the admission, then the patient may be treated via observation and the provider shall seek reimbursement accordingly. Nothing in this Section shall diminish the requirements of a provider to document medical necessity in the patient's record.

Article 10.

Section 10-5. The Illinois Public Aid Code is amended by changing Section 5-8 as follows:

(305 ILCS 5/5-8) (from Ch. 23, par. 5-8)

Sec. 5-8. Practitioners. In supplying medical assistance, the Illinois Department may provide for the legally authorized services of (i) persons licensed under the Medical Practice Act of 1987, as amended, except as hereafter in this Section stated, whether under a general or limited license, (ii) persons licensed under the Nurse Practice Act as advanced practice registered nurses, regardless of whether or not the persons have written collaborative agreements, (iii) persons licensed or registered under other laws of this State to provide dental, medical, pharmaceutical, optometric, podiatric, or nursing services, or other remedial care

recognized under State law, (iv) persons licensed under other laws of this State as a clinical social worker, and (v) persons licensed under other laws of this State as physician assistants. The Department shall adopt rules, no later than 90 days after January 1, 2017 (the effective date of Public Act 99-621), for the legally authorized services of persons licensed under other laws of this State as a clinical social worker. The Department shall provide for the legally authorized services of persons licensed under the Professional Counselor and Clinical Professional Counselor Licensing and Practice Act as clinical professional counselors and for the legally authorized services of persons licensed under the Marriage and Family Therapy Licensing Act as marriage and family therapists. The utilization of the services of persons engaged in the treatment or care of the sick, which persons are not required to be licensed or registered under the laws of this State, is not prohibited by this Section.

(Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17; 100-453, eff. 8-25-17; 100-513, eff. 1-1-18; 100-538, eff. 1-1-18; 100-863, eff. 8-14-18.)

Article 15.

Section 15-5. The Department of Healthcare and Family Services Law of the Civil Administrative Code of Illinois is amended by adding Section 2205-35 as follows:

(20 ILCS 2205/2205-35 new)

Sec. 2205-35. Certified veteran support specialists. The Department of Healthcare and Family Services shall recognize veteran support specialists who are certified by, and in good standing with, the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc. as mental health professionals as defined in the Illinois Title XIX State Plan and in 89 Ill. Adm. Code 140.453.

Article 20.

Section 20-5. The Illinois Public Aid Code is amended by adding Section 5-5.4k as follows:

(305 ILCS 5/5-5.4k new)

Sec. 5-5.4k. Payments for long-acting injectable medications for mental health or substance use disorders. Notwithstanding any other provision of this Code, effective for dates of service on and after January 1, 2022, the medical assistance program shall separately reimburse at the prevailing fee schedule, for long-acting injectable medications administered for mental health or substance use disorder in the hospital inpatient setting, and which are compliant with the prior authorization requirements of this Section. The Department, in consultation with a statewide

association representing a majority of hospitals and Managed Care Organizations shall implement, by rule, reimbursement policy and prior authorization criteria for the use of long-acting injectable medications administered in the hospital inpatient setting for the treatment of mental health disorders.

Article 25.

Section 25-3. The Illinois Administrative Procedure Act is amended by adding Section 5-45.8 as follows:

(5 ILCS 100/5-45.8 new)

Sec. 5-45.8. Emergency rulemaking; Medicaid eligibility expansion. To provide for the expeditious and timely implementation of the changes made to paragraph 6 of Section 5-2 of the Illinois Public Aid Code by this amendatory Act of the 102nd General Assembly, emergency rules implementing the changes made to paragraph 6 of Section 5-2 of the Illinois Public Aid Code by this amendatory Act of the 102nd General Assembly may be adopted in accordance with Section 5-45 by the Department of Healthcare and Family Services. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed on January 1, 2027.

Section 25-5. The Children's Health Insurance Program Act is amended by adding Section 6 as follows:

(215 ILCS 106/6 new)

Sec. 6. Act inoperative. This Act is inoperative if (i) the Department of Healthcare and Family Services receives federal approval to make children younger than 19 who have countable income at or below 313% of the federal poverty level eligible for medical assistance under Article V of the Illinois Public Aid Code and (ii) the Department, upon federal approval, transitions children eligible for health care benefits under this Act into the medical assistance program established under Article V of the Illinois Public Aid Code.

Section 25-10. The Covering ALL KIDS Health Insurance Act is amended by adding Section 6 as follows:

(215 ILCS 170/6 new)

Sec. 6. Act inoperative. This Act is inoperative if (i) the Department of Healthcare and Family Services receives federal approval to make children younger than 19 who have countable income at or below 313% of the federal poverty level eligible for medical assistance under Article V of the Illinois Public Aid Code and (ii) the Department, upon federal approval, transitions children eligible for health care

benefits under this Act into the medical assistance program established under Article V of the Illinois Public Aid Code.

Section 25-15. The Illinois Public Aid Code is amended by changing Sections 5-1.5, 5-2, and 12-4.35, and by adding Sections 11-4.2, 11-22d, and 11-32 as follows:

(305 ILCS 5/5-1.5)

Sec. 5-1.5. COVID-19 public health emergency. Notwithstanding any other provision of Articles V, XI, and XII of this Code, the Department may take necessary actions to address the COVID-19 public health emergency to the extent such actions are required, approved, or authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Such actions may continue throughout the public health emergency and for up to 12 months after the period ends, and may include, but are not limited to: accepting an applicant's or recipient's attestation of income, incurred medical expenses, residency, and insured status when electronic verification is not available; eliminating resource tests for some eligibility determinations; suspending redeterminations; suspending changes that would adversely affect an applicant's or recipient's eligibility; phone or verbal approval by an applicant to submit an application in lieu of applicant signature; allowing adult presumptive eligibility; allowing presumptive eligibility for children,

pregnant women, and adults as often as twice per calendar year; paying for additional services delivered by telehealth; and suspending premium and co-payment requirements.

The Department's authority under this Section shall ~~only~~ extend to encompass, incorporate, or effectuate the terms, items, conditions, and other provisions approved, authorized, or required by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and shall not extend beyond the time of the COVID-19 public health emergency and up to 12 months after the period expires.

Any individual determined eligible for medical assistance under this Code as of or during the COVID-19 public health emergency may be treated as eligible for such medical assistance benefits during the COVID-19 public health emergency, and up to 12 months after the period expires, regardless of whether federally required or whether the individual's eligibility may be State or federally funded, unless the individual requests a voluntary termination of eligibility or ceases to be a resident. This paragraph shall not restrict any determination of medical need or appropriateness for any particular service and shall not require continued coverage of any particular service that may be no longer necessary, appropriate, or otherwise authorized for an individual. Nothing shall prevent the Department from determining and properly establishing an individual's eligibility under a different category of eligibility.

(Source: P.A. 101-649, eff. 7-7-20.)

(305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

Sec. 5-2. Classes of persons eligible. Medical assistance under this Article shall be available to any of the following classes of persons in respect to whom a plan for coverage has been submitted to the Governor by the Illinois Department and approved by him. If changes made in this Section 5-2 require federal approval, they shall not take effect until such approval has been received:

1. Recipients of basic maintenance grants under Articles III and IV.

2. Beginning January 1, 2014, persons otherwise eligible for basic maintenance under Article III, excluding any eligibility requirements that are inconsistent with any federal law or federal regulation, as interpreted by the U.S. Department of Health and Human Services, but who fail to qualify thereunder on the basis of need, and who have insufficient income and resources to meet the costs of necessary medical care, including, but not limited to, the following:

(a) All persons otherwise eligible for basic maintenance under Article III but who fail to qualify under that Article on the basis of need and who meet either of the following requirements:

(i) their income, as determined by the

Illinois Department in accordance with any federal requirements, is equal to or less than 100% of the federal poverty level; or

(ii) their income, after the deduction of costs incurred for medical care and for other types of remedial care, is equal to or less than 100% of the federal poverty level.

(b) (Blank).

3. (Blank).

4. Persons not eligible under any of the preceding paragraphs who fall sick, are injured, or die, not having sufficient money, property or other resources to meet the costs of necessary medical care or funeral and burial expenses.

5.(a) Beginning January 1, 2020, women during pregnancy and during the 12-month period beginning on the last day of the pregnancy, together with their infants, whose income is at or below 200% of the federal poverty level. Until September 30, 2019, or sooner if the maintenance of effort requirements under the Patient Protection and Affordable Care Act are eliminated or may be waived before then, women during pregnancy and during the 12-month period beginning on the last day of the pregnancy, whose countable monthly income, after the deduction of costs incurred for medical care and for other types of remedial care as specified in administrative

rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1, 2013 as set forth in administrative rule.

(b) The plan for coverage shall provide ambulatory prenatal care to pregnant women during a presumptive eligibility period and establish an income eligibility standard that is equal to 200% of the federal poverty level, provided that costs incurred for medical care are not taken into account in determining such income eligibility.

(c) The Illinois Department may conduct a demonstration in at least one county that will provide medical assistance to pregnant women, together with their infants and children up to one year of age, where the income eligibility standard is set up to 185% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget. The Illinois Department shall seek and obtain necessary authorization provided under federal law to implement such a demonstration. Such demonstration may establish resource standards that are not more restrictive than those established under Article IV of this Code.

6. (a) Subject to federal approval, children ~~Children~~ younger than age 19 when countable income is at or below 313% ~~133%~~ of the federal poverty level, as determined by the Department and in accordance with all applicable

federal requirements. The Department is authorized to adopt emergency rules to implement the changes made to this paragraph by this amendatory Act of the 102nd General Assembly. Until September 30, 2019, or sooner if the maintenance of effort requirements under the Patient Protection and Affordable Care Act are eliminated or may be waived before then, children younger than age 19 whose countable monthly income, after the deduction of costs incurred for medical care and for other types of remedial care as specified in administrative rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1, 2013 as set forth in administrative rule.

(b) Children and youth who are under temporary custody or guardianship of the Department of Children and Family Services or who receive financial assistance in support of an adoption or guardianship placement from the Department of Children and Family Services.

7. (Blank).

8. As required under federal law, persons who are eligible for Transitional Medical Assistance as a result of an increase in earnings or child or spousal support received. The plan for coverage for this class of persons shall:

(a) extend the medical assistance coverage to the extent required by federal law; and

(b) offer persons who have initially received 6 months of the coverage provided in paragraph (a) above, the option of receiving an additional 6 months of coverage, subject to the following:

(i) such coverage shall be pursuant to provisions of the federal Social Security Act;

(ii) such coverage shall include all services covered under Illinois' State Medicaid Plan;

(iii) no premium shall be charged for such coverage; and

(iv) such coverage shall be suspended in the event of a person's failure without good cause to file in a timely fashion reports required for this coverage under the Social Security Act and coverage shall be reinstated upon the filing of such reports if the person remains otherwise eligible.

9. Persons with acquired immunodeficiency syndrome (AIDS) or with AIDS-related conditions with respect to whom there has been a determination that but for home or community-based services such individuals would require the level of care provided in an inpatient hospital, skilled nursing facility or intermediate care facility the cost of which is reimbursed under this Article. Assistance shall be provided to such persons to the maximum extent permitted under Title XIX of the Federal Social Security

Act.

10. Participants in the long-term care insurance partnership program established under the Illinois Long-Term Care Partnership Program Act who meet the qualifications for protection of resources described in Section 15 of that Act.

11. Persons with disabilities who are employed and eligible for Medicaid, pursuant to Section 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and, subject to federal approval, persons with a medically improved disability who are employed and eligible for Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of the Social Security Act, as provided by the Illinois Department by rule. In establishing eligibility standards under this paragraph 11, the Department shall, subject to federal approval:

(a) set the income eligibility standard at not lower than 350% of the federal poverty level;

(b) exempt retirement accounts that the person cannot access without penalty before the age of 59 1/2, and medical savings accounts established pursuant to 26 U.S.C. 220;

(c) allow non-exempt assets up to $25,000 as to those assets accumulated during periods of eligibility under this paragraph 11; and

(d) continue to apply subparagraphs (b) and (c) in

determining the eligibility of the person under this Article even if the person loses eligibility under this paragraph 11.

12. Subject to federal approval, persons who are eligible for medical assistance coverage under applicable provisions of the federal Social Security Act and the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000. Those eligible persons are defined to include, but not be limited to, the following persons:

(1) persons who have been screened for breast or cervical cancer under the U.S. Centers for Disease Control and Prevention Breast and Cervical Cancer Program established under Title XV of the federal Public Health Service ~~Services~~ Act in accordance with the requirements of Section 1504 of that Act as administered by the Illinois Department of Public Health; and

(2) persons whose screenings under the above program were funded in whole or in part by funds appropriated to the Illinois Department of Public Health for breast or cervical cancer screening.

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the coverage under this paragraph 12 within 30 days after July

3, 2001 (the effective date of Public Act 92-47) ~~this amendatory Act of the 92nd General Assembly~~.

In addition to the persons who are eligible for medical assistance pursuant to subparagraphs (1) and (2) of this paragraph 12, and to be paid from funds appropriated to the Department for its medical programs, any uninsured person as defined by the Department in rules residing in Illinois who is younger than 65 years of age, who has been screened for breast and cervical cancer in accordance with standards and procedures adopted by the Department of Public Health for screening, and who is referred to the Department by the Department of Public Health as being in need of treatment for breast or cervical cancer is eligible for medical assistance benefits that are consistent with the benefits provided to those persons described in subparagraphs (1) and (2). Medical assistance coverage for the persons who are eligible under the preceding sentence is not dependent on federal approval, but federal moneys may be used to pay for services provided under that coverage upon federal approval.

13. Subject to appropriation and to federal approval, persons living with HIV/AIDS who are not otherwise eligible under this Article and who qualify for services covered under Section 5-5.04 as provided by the Illinois Department by rule.

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet the income guidelines of paragraph 2(a) of this Section and (i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

(a) On and after July 1, 2012, a parent or other caretaker relative who is 19 years of age or older when

countable income is at or below 133% of the federal poverty level. A person may not spend down to become eligible under this paragraph 15.

(b) Eligibility shall be reviewed annually.

(c) (Blank).

(d) (Blank).

(e) (Blank).

(f) (Blank).

(g) (Blank).

(h) (Blank).

(i) Following termination of an individual's coverage under this paragraph 15, the individual must be determined eligible before the person can be re-enrolled.

16. Subject to appropriation, uninsured persons who are not otherwise eligible under this Section who have been certified and referred by the Department of Public Health as having been screened and found to need diagnostic evaluation or treatment, or both diagnostic evaluation and treatment, for prostate or testicular cancer. For the purposes of this paragraph 16, uninsured persons are those who do not have creditable coverage, as defined under the Health Insurance Portability and Accountability Act, or have otherwise exhausted any insurance benefits they may have had, for prostate or testicular cancer diagnostic evaluation or treatment, or

both diagnostic evaluation and treatment. To be eligible, a person must furnish a Social Security number. A person's assets are exempt from consideration in determining eligibility under this paragraph 16. Such persons shall be eligible for medical assistance under this paragraph 16 for so long as they need treatment for the cancer. A person shall be considered to need treatment if, in the opinion of the person's treating physician, the person requires therapy directed toward cure or palliation of prostate or testicular cancer, including recurrent metastatic cancer that is a known or presumed complication of prostate or testicular cancer and complications resulting from the treatment modalities themselves. Persons who require only routine monitoring services are not considered to need treatment. "Medical assistance" under this paragraph 16 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. Notwithstanding any other provision of law, the Department (i) does not have a claim against the estate of a deceased recipient of services under this paragraph 16 and (ii) does not have a lien against any homestead property or other legal or equitable real property interest owned by a recipient of services under this paragraph 16.

17. Persons who, pursuant to a waiver approved by the Secretary of the U.S. Department of Health and Human

Services, are eligible for medical assistance under Title XIX or XXI of the federal Social Security Act. Notwithstanding any other provision of this Code and consistent with the terms of the approved waiver, the Illinois Department, may by rule:

(a) Limit the geographic areas in which the waiver program operates.

(b) Determine the scope, quantity, duration, and quality, and the rate and method of reimbursement, of the medical services to be provided, which may differ from those for other classes of persons eligible for assistance under this Article.

(c) Restrict the persons' freedom in choice of providers.

18. Beginning January 1, 2014, persons aged 19 or older, but younger than 65, who are not otherwise eligible for medical assistance under this Section 5-2, who qualify for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) and applicable federal regulations, and who have income at or below 133% of the federal poverty level plus 5% for the applicable family size as determined pursuant to 42 U.S.C. 1396a(e)(14) and applicable federal regulations. Persons eligible for medical assistance under this paragraph 18 shall receive coverage for the Health Benefits Service Package as that term is defined in subsection (m) of Section 5-1.1 of this

Code. If Illinois' federal medical assistance percentage (FMAP) is reduced below 90% for persons eligible for medical assistance under this paragraph 18, eligibility under this paragraph 18 shall cease no later than the end of the third month following the month in which the reduction in FMAP takes effect.

19. Beginning January 1, 2014, as required under 42 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18 and younger than age 26 who are not otherwise eligible for medical assistance under paragraphs (1) through (17) of this Section who (i) were in foster care under the responsibility of the State on the date of attaining age 18 or on the date of attaining age 21 when a court has continued wardship for good cause as provided in Section 2-31 of the Juvenile Court Act of 1987 and (ii) received medical assistance under the Illinois Title XIX State Plan or waiver of such plan while in foster care.

20. Beginning January 1, 2018, persons who are foreign-born victims of human trafficking, torture, or other serious crimes as defined in Section 2-19 of this Code and their derivative family members if such persons: (i) reside in Illinois; (ii) are not eligible under any of the preceding paragraphs; (iii) meet the income guidelines of subparagraph (a) of paragraph 2; and (iv) meet the nonfinancial eligibility requirements of Sections 16-2, 16-3, and 16-5 of this Code. The Department may extend

medical assistance for persons who are foreign-born victims of human trafficking, torture, or other serious crimes whose medical assistance would be terminated pursuant to subsection (b) of Section 16-5 if the Department determines that the person, during the year of initial eligibility (1) experienced a health crisis, (2) has been unable, after reasonable attempts, to obtain necessary information from a third party, or (3) has other extenuating circumstances that prevented the person from completing his or her application for status. The Department may adopt any rules necessary to implement the provisions of this paragraph.

21. Persons who are not otherwise eligible for medical assistance under this Section who may qualify for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the duration of any federal or State declared emergency due to COVID-19. Medical assistance to persons eligible for medical assistance solely pursuant to this paragraph 21 shall be limited to any in vitro diagnostic product (and the administration of such product) described in 42 U.S.C. 1396d(a)(3)(B) on or after March 18, 2020, any visit described in 42 U.S.C. 1396o(a)(2)(G), or any other medical assistance that may be federally authorized for this class of persons. The Department may also cover treatment of COVID-19 for this class of persons, or any

similar category of uninsured individuals, to the extent authorized under a federally approved 1115 Waiver or other federal authority. Notwithstanding the provisions of Section 1-11 of this Code, due to the nature of the COVID-19 public health emergency, the Department may cover and provide the medical assistance described in this paragraph 21 to noncitizens who would otherwise meet the eligibility requirements for the class of persons described in this paragraph 21 for the duration of the State emergency period.

In implementing the provisions of Public Act 96-20, the Department is authorized to adopt only those rules necessary, including emergency rules. Nothing in Public Act 96-20 permits the Department to adopt rules or issue a decision that expands eligibility for the FamilyCare Program to a person whose income exceeds 185% of the Federal Poverty Level as determined from time to time by the U.S. Department of Health and Human Services, unless the Department is provided with express statutory authority.

The eligibility of any such person for medical assistance under this Article is not affected by the payment of any grant under the Senior Citizens and Persons with Disabilities Property Tax Relief Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act.

The Department shall by rule establish the amounts of

assets to be disregarded in determining eligibility for medical assistance, which shall at a minimum equal the amounts to be disregarded under the Federal Supplemental Security Income Program. The amount of assets of a single person to be disregarded shall not be less than $2,000, and the amount of assets of a married couple to be disregarded shall not be less than $3,000.

To the extent permitted under federal law, any person found guilty of a second violation of Article VIIIA shall be ineligible for medical assistance under this Article, as provided in Section 8A-8.

The eligibility of any person for medical assistance under this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person in cases of serious illness, as long as neither the person nor members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

Notwithstanding any other provision of this Code, if the United States Supreme Court holds Title II, Subtitle A, Section 2001(a) of Public Law 111-148 to be unconstitutional, or if a holding of Public Law 111-148 makes Medicaid eligibility allowed under Section 2001(a) inoperable, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal approval of a State Medicaid waiver on or

after June 14, 2012 (the effective date of Public Act 97-687) ~~this amendatory Act of the 97th General Assembly~~, and any individuals enrolled in the Medical Assistance Program pursuant to eligibility permitted as a result of such a State Medicaid waiver shall become immediately ineligible.

Notwithstanding any other provision of this Code, if an Act of Congress that becomes a Public Law eliminates Section 2001(a) of Public Law 111-148, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal approval of a State Medicaid waiver on or after June 14, 2012 (the effective date of Public Act 97-687) ~~this amendatory Act of the 97th General Assembly~~, and any individuals enrolled in the Medical Assistance Program pursuant to eligibility permitted as a result of such a State Medicaid waiver shall become immediately ineligible.

Effective October 1, 2013, the determination of eligibility of persons who qualify under paragraphs 5, 6, 8, 15, 17, and 18 of this Section shall comply with the requirements of 42 U.S.C. 1396a(e)(14) and applicable federal regulations.

The Department of Healthcare and Family Services, the Department of Human Services, and the Illinois health insurance marketplace shall work cooperatively to assist persons who would otherwise lose health benefits as a result of changes made under Public Act 98-104 ~~this amendatory Act of~~

~~the 98th General Assembly~~ to transition to other health insurance coverage.

(Source: P.A. 101-10, eff. 6-5-19; 101-649, eff. 7-7-20; revised 8-24-20.)

(305 ILCS 5/11-4.2 new)

Sec. 11-4.2. Application assistance for enrolling individuals in the medical assistance program.

(a) The Department shall have procedures to allow application agents to assist in enrolling individuals in the medical assistance program. As used in this Section, "application agent" means an organization or individual, such as a licensed health care provider, school, youth service agency, employer, labor union, local chamber of commerce, community-based organization, or other organization, approved by the Department to assist in enrolling individuals in the medical assistance program.

(b) At the Department's discretion, technical assistance payments may be made available for approved applications facilitated by an application agent. The Department shall permit day and temporary labor service agencies, as defined in the Day and Temporary Labor Services Act, doing business in Illinois to enroll as unpaid application agents. As established in the Free Healthcare Benefits Application Assistance Act, it shall be unlawful for any person to charge another person or family for assisting in completing and

submitting an application for enrollment in the medical assistance program.

(c) Existing enrollment agreements or contracts for all application agents, technical assistance payments, and outreach grants that were authorized under Section 22 of the Children's Health Insurance Program Act and Sections 25 and 30 of the Covering ALL KIDS Health Insurance Act prior to those Acts becoming inoperative shall continue to be authorized under this Section per the terms of the agreement or contract until modified, amended, or terminated.

(305 ILCS 5/11-22d new)

Sec. 11-22d. Savings provisions.

(a) Notwithstanding any amendments or provisions in this amendatory Act of the 102nd General Assembly which would make the Children's Health Insurance Program Act or the Covering ALL KIDS Health Insurance Act inoperative, Sections 11-22a, 11-22b, and 11-22c of this Code shall remain in force for the commencement or continuation of any cause of action that (i) accrued prior to the effective date of this amendatory Act of the 102nd General Assembly or the date upon which the Department receives federal approval of the changes made to paragraph (6) of Section 5-2 by this amendatory Act of the 102nd General Assembly, whichever is later, and (ii) concerns the recovery of any amount expended by the State for health care benefits provided under the Children's Health Insurance

Program Act or the Covering ALL KIDS Health Insurance Act prior to those Acts becoming inoperative. Any timely action brought under Sections 11-22a, 11-22b, and 11-22c shall be decided in accordance with those Sections as they existed when the cause of action accrued.

(b) Notwithstanding any amendments or provisions in this amendatory Act of the 102nd General Assembly which would make the Children's Health Insurance Program Act or the Covering ALL KIDS Health Insurance Act inoperative, paragraph (2) of Section 12-9 of this Code shall remain in force as to recoveries made by the Department of Healthcare and Family Services from any cause of action commenced or continued in accordance with subsection (a).

(305 ILCS 5/11-32 new)

Sec. 11-32. Premium debts; forgiveness, compromise, reduction. The Department may forgive, compromise, or reduce any debt owed by a former or current recipient of medical assistance under this Code or health care benefits under the Children's Health Insurance Program or the Covering ALL KIDS Health Insurance Program that is related to any premium that was determined or imposed in accordance with (i) the Children's Health Insurance Program Act or the Covering ALL KIDS Health Insurance Act prior to those Acts becoming inoperative or (ii) any corresponding administrative rule.

(305 ILCS 5/12-4.35)

Sec. 12-4.35. Medical services for certain noncitizens.

(a) Notwithstanding Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act, the Department of Healthcare and Family Services may provide medical services to noncitizens who have not yet attained 19 years of age and who are not eligible for medical assistance under Article V of this Code or under the Children's Health Insurance Program created by the Children's Health Insurance Program Act due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code or the Children's Health Insurance Program created by the Children's Health Insurance Program Act.

(a-5) Notwithstanding Section 1-11 of this Code, the Department of Healthcare and Family Services may provide medical assistance in accordance with Article V of this Code to noncitizens over the age of 65 years of age who are not eligible for medical assistance under Article V of this Code due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code, whose income is at or below 100% of the federal poverty level after deducting the costs of

medical or other remedial care, and who would otherwise meet the eligibility requirements in Section 5-2 of this Code. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code.

(b) The Department is authorized to take any action that would not otherwise be prohibited by applicable law, including without limitation cessation or limitation of enrollment, reduction of available medical services, and changing standards for eligibility, that is deemed necessary by the Department during a State fiscal year to assure that payments under this Section do not exceed available funds.

(c) (Blank). ~~Continued enrollment of individuals into the program created under subsection (a) of this Section in any fiscal year is contingent upon continued enrollment of individuals into the Children's Health Insurance Program during that fiscal year.~~

(d) (Blank).

(Source: P.A. 101-636, eff. 6-10-20.)

Article 30.

Section 30-5. The Illinois Public Aid Code is amended by changing Sections 5-5 and 5-5f as follows:

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative

services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; <u>(16.5) services performed by a chiropractic physician licensed under the Medical Practice Act of 1987 and acting within the scope of his or her license, including, but not limited to, chiropractic manipulative treatment;</u> and (17) any other medical care, and any other type of remedial care recognized under the laws of this State. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

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

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

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department shall authorize the Chicago Public Schools (CPS) to procure a vendor or vendors to manufacture eyeglasses for individuals enrolled in a school within the CPS system. CPS shall ensure that its vendor or vendors are enrolled as providers in the medical assistance program and in any capitated Medicaid

managed care entity (MCE) serving individuals enrolled in a school within the CPS system. Under any contract procured under this provision, the vendor or vendors must serve only individuals enrolled in a school within the CPS system. Claims for services provided by CPS's vendor or vendors to recipients of benefits in the medical assistance program under this Code, the Children's Health Insurance Program, or the Covering ALL KIDS Health Insurance Program shall be submitted to the Department or the MCE in which the individual is enrolled for payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses.

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

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

(2) eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever 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 enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other enrolled provider, as determined by the

Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

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

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

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

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

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

(C) A mammogram at the age and intervals considered medically necessary by the woman's health care provider

for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

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

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

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

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

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

tool.

For purposes of this Section:

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

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

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

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

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the

Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

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

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

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

On and after January 1, 2017, providers participating in a breast cancer treatment quality improvement program approved

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

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

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

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

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

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

The Department shall require all networks of care to develop a means either internally or by contract with experts in navigation and community outreach to navigate cancer patients to comprehensive care in a timely fashion. The Department shall require all networks of care to include access for patients diagnosed with cancer to at least one

academic commission on cancer-accredited cancer program as an in-network covered benefit.

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

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

The Illinois Department, in cooperation with the Departments of Human Services (as successor to the Department of Alcoholism and Substance Abuse) and Public Health, through a public awareness campaign, may provide information concerning treatment for alcoholism and drug abuse and

addiction, prenatal health care, and other pertinent programs directed at reducing the number of drug-affected infants born to recipients of medical assistance.

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

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

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

The sponsor must negotiate formal written contracts with

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

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

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

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

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the delivery of high quality medical services. These qualifications shall be determined by rule of the Illinois Department and may be higher than qualifications for

participation in the medical assistance program. Partnership sponsors may prescribe reasonable additional qualifications for participation by medical providers, only with the prior written approval of the Illinois Department.

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

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

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

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

medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

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

technology platforms are implemented.

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

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

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

penalty.

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

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

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.

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

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

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

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

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

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

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

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

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Illinois Department shall develop, in cooperation with other State departments and agencies, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including, but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of

Human Services; and the Department of Financial and Professional Regulation.

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

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

maintaining such equipment. Subject to prior approval, such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department. Notwithstanding any provision of Section 5-5f to the contrary, the Department may, by rule, exempt certain replacement wheelchair parts from prior approval and, for wheelchairs, wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

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

In order to promote environmental responsibility, meet the needs of recipients and enrollees, and achieve significant cost savings, the Department, or a managed care organization under contract with the Department, may provide recipients or managed care enrollees who have a prescription or Certificate of Medical Necessity access to refurbished durable medical equipment under this Section (excluding prosthetic and

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

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common

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

approval has been granted.

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

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

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

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

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

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

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act, and filing such additional copies with the State

Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

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

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

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

Providers under this Section shall be prior approved and certified by the Department to perform kidney transplantation and the services under this Section shall be limited to services associated with kidney transplantation.

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

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

the U.S. Food and Drug Administration.

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

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

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

1-1-20; revised 9-18-19.)

(305 ILCS 5/5-5f)

Sec. 5-5f. Elimination and limitations of medical assistance services. Notwithstanding any other provision of this Code to the contrary, on and after July 1, 2012:

(a) The following service ~~services~~ shall no longer be a covered service available under this Code: group psychotherapy for residents of any facility licensed under the Nursing Home Care Act or the Specialized Mental Health Rehabilitation Act of 2013~~; and adult chiropractic services~~.

(b) The Department shall place the following limitations on services: (i) the Department shall limit adult eyeglasses to one pair every 2 years; however, the limitation does not apply to an individual who needs different eyeglasses following a surgical procedure such as cataract surgery; (ii) the Department shall set an annual limit of a maximum of 20 visits for each of the following services: adult speech, hearing, and language therapy services, adult occupational therapy services, and physical therapy services; on or after October 1, 2014, the annual maximum limit of 20 visits shall expire but the Department may require prior approval for all individuals for speech, hearing, and language therapy services, occupational therapy services, and physical therapy

services; (iii) the Department shall limit adult podiatry services to individuals with diabetes; on or after October 1, 2014, podiatry services shall not be limited to individuals with diabetes; (iv) the Department shall pay for caesarean sections at the normal vaginal delivery rate unless a caesarean section was medically necessary; (v) the Department shall limit adult dental services to emergencies; beginning July 1, 2013, the Department shall ensure that the following conditions are recognized as emergencies: (A) dental services necessary for an individual in order for the individual to be cleared for a medical procedure, such as a transplant; (B) extractions and dentures necessary for a diabetic to receive proper nutrition; (C) extractions and dentures necessary as a result of cancer treatment; and (D) dental services necessary for the health of a pregnant woman prior to delivery of her baby; on or after July 1, 2014, adult dental services shall no longer be limited to emergencies, and dental services necessary for the health of a pregnant woman prior to delivery of her baby shall continue to be covered; and (vi) effective July 1, 2012, the Department shall place limitations and require concurrent review on every inpatient detoxification stay to prevent repeat admissions to any hospital for detoxification within 60 days of a previous inpatient detoxification stay. The Department shall convene a workgroup of hospitals,

substance abuse providers, care coordination entities, managed care plans, and other stakeholders to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification, which shall be published on the Department's website no later than September 1, 2013.

(c) The Department shall require prior approval of the following services: wheelchair repairs costing more than $400, coronary artery bypass graft, and bariatric surgery consistent with Medicare standards concerning patient responsibility. Wheelchair repair prior approval requests shall be adjudicated within one business day of receipt of complete supporting documentation. Providers may not break wheelchair repairs into separate claims for purposes of staying under the $400 threshold for requiring prior approval. The wholesale price of manual and power wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

(d) The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care

and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a minimum, $40,000,000.

(e) The Department shall establish utilization controls for the hospice program such that it shall not pay for other care services when an individual is in hospice.

(f) For home health services, the Department shall require Medicare certification of providers participating in the program and implement the Medicare face-to-face encounter rule. The Department shall require providers to implement auditable electronic service verification based on global positioning systems or other cost-effective technology.

(g) For the Home Services Program operated by the Department of Human Services and the Community Care Program operated by the Department on Aging, the Department of Human Services, in cooperation with the Department on Aging, shall implement an electronic service verification based on global positioning systems or other

cost-effective technology.

(h) Effective with inpatient hospital admissions on or after July 1, 2012, the Department shall reduce the payment for a claim that indicates the occurrence of a provider-preventable condition during the admission as specified by the Department in rules. The Department shall not pay for services related to an other provider-preventable condition.

As used in this subsection (h):

"Provider-preventable condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 or an other provider-preventable condition.

"Other provider-preventable condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

(i) The Department shall implement cost savings initiatives for advanced imaging services, cardiac imaging services, pain management services, and back surgery. Such initiatives shall be designed to achieve annual costs savings.

(j) The Department shall ensure that beneficiaries with a diagnosis of epilepsy or seizure disorder in Department records will not require prior approval for

anticonvulsants.

(Source: P.A. 100-135, eff. 8-18-17; 101-209, eff. 8-5-19.)

Article 35.

Section 35-5. The Illinois Public Aid Code is amended by changing Section 5-5 and by adding Section 5-42 as follows:

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or

corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the

laws of this State. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

Notwithstanding any other provision of this Section, all tobacco cessation medications approved by the United States Food and Drug Administration and all individual and group tobacco cessation counseling services and telephone-based counseling services and tobacco cessation medications provided through the Illinois Tobacco Quitline shall be covered under the medical assistance program for persons who are otherwise eligible for assistance under this Article. The Department shall comply with all federal requirements necessary to obtain federal financial participation, as specified in 42 CFR 433.15(b)(7), for telephone-based counseling services provided through the Illinois Tobacco Quitline, including, but not limited to: (i) entering into a memorandum of understanding or interagency agreement with the Department of Public Health, as administrator of the Illinois Tobacco Quitline; and (ii)

developing a cost allocation plan for Medicaid-allowable Illinois Tobacco Quitline services in accordance with 45 CFR 95.507. The Department shall submit the memorandum of understanding or interagency agreement, the cost allocation plan, and all other necessary documentation to the Centers for Medicare and Medicaid Services for review and approval. Coverage under this paragraph shall be contingent upon federal approval.

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

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

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department shall authorize the Chicago Public Schools (CPS) to procure a vendor or vendors to manufacture eyeglasses for individuals enrolled in a school within the CPS system. CPS shall ensure that its vendor or vendors are enrolled as providers in the

medical assistance program and in any capitated Medicaid managed care entity (MCE) serving individuals enrolled in a school within the CPS system. Under any contract procured under this provision, the vendor or vendors must serve only individuals enrolled in a school within the CPS system. Claims for services provided by CPS's vendor or vendors to recipients of benefits in the medical assistance program under this Code, the Children's Health Insurance Program, or the Covering ALL KIDS Health Insurance Program shall be submitted to the Department or the MCE in which the individual is enrolled for payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses.

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

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

(2) eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever 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 enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health

Center or other enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

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

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

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

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

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

(C) A mammogram at the age and intervals considered

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

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

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

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

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

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

frequency of self-examination and its value as a preventative tool.

For purposes of this Section:

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

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

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

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

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that

would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

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

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

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

On and after January 1, 2017, providers participating in a

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

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

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

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

evaluation.

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

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

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

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

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

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

The Illinois Department, in cooperation with the Departments of Human Services (as successor to the Department of Alcoholism and Substance Abuse) and Public Health, through a public awareness campaign, may provide information

concerning treatment for alcoholism and drug abuse and addiction, prenatal health care, and other pertinent programs directed at reducing the number of drug-affected infants born to recipients of medical assistance.

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

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

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

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

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

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

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

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the delivery of high quality medical services. These qualifications shall be determined by rule of the Illinois

Department and may be higher than qualifications for participation in the medical assistance program. Partnership sponsors may prescribe reasonable additional qualifications for participation by medical providers, only with the prior written approval of the Illinois Department.

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

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

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

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

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

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

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

operational or structural changes to its information technology platforms are implemented.

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

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

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

process. However, a disenrolled vendor may reapply without penalty.

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

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

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.

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

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

For claims for services rendered during a period for which a recipient received retroactive eligibility, claims must be

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

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

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

To the extent consistent with applicable information and privacy, security, and disclosure laws, State and federal

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

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Illinois Department shall develop, in cooperation with other State departments and agencies, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including, but not limited to: the Secretary of State; the Department of

Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

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

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of

the recipient's needs, and the requirements and costs for maintaining such equipment. Subject to prior approval, such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department. Notwithstanding any provision of Section 5-5f to the contrary, the Department may, by rule, exempt certain replacement wheelchair parts from prior approval and, for wheelchairs, wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

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

In order to promote environmental responsibility, meet the needs of recipients and enrollees, and achieve significant cost savings, the Department, or a managed care organization under contract with the Department, may provide recipients or managed care enrollees who have a prescription or Certificate of Medical Necessity access to refurbished durable medical

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

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to

effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped; and (iii) notwithstanding any other provision of law, subject to federal approval, on and after July 1, 2012, an increase in the determination of need (DON) scores from 29 to 37 for applicants for institutional and home and community-based long term care; if and only if federal approval is not granted, the Department may, in conjunction with other affected agencies, implement utilization controls or changes in benefit packages to effectuate a similar savings amount for this population; and (iv) no later than July 1, 2013, minimum level of care eligibility criteria for institutional and home and community-based long term care; and (v) no later than October 1, 2013, establish procedures to permit long term care providers access to eligibility scores for individuals with an admission date who are seeking or receiving services from the long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for

community-based services in circumstances where federal approval has been granted.

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

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

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

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

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

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

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization

Act, and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

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

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

Because kidney transplantation can be an appropriate, cost-effective alternative to renal dialysis when medically necessary and notwithstanding the provisions of Section 1-11 of this Code, beginning October 1, 2014, the Department shall cover kidney transplantation for noncitizens with end-stage renal disease who are not eligible for comprehensive medical benefits, who meet the residency requirements of Section 5-3 of this Code, and who would otherwise meet the financial requirements of the appropriate class of eligible persons under Section 5-2 of this Code. To qualify for coverage of kidney transplantation, such person must be receiving

emergency renal dialysis services covered by the Department. Providers under this Section shall be prior approved and certified by the Department to perform kidney transplantation and the services under this Section shall be limited to services associated with kidney transplantation.

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

On or after July 1, 2015, opioid antagonists prescribed for the treatment of an opioid overdose, including the medication product, administration devices, and any pharmacy fees related to the dispensing and administration of the opioid antagonist, shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article. As used in this Section, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone

hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

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

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

(Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;

100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; revised 9-18-19.)

(305 ILCS 5/5-42 new)

Sec. 5-42. Tobacco cessation coverage; managed care. Notwithstanding any other provision of this Article, a managed care organization under contract with the Department to provide services to recipients of medical assistance shall provide coverage for all tobacco cessation medications approved by the United States Food and Drug Administration, all individual and group tobacco cessation counseling services, and all telephone-based counseling services and tobacco cessation medications provided through the Illinois Tobacco Quitline. The Department may adopt any rules necessary to implement this Section.

Article 45.

Section 45-5. The Illinois Public Aid Code is amended by changing Section 12-4.35 as follows:

(305 ILCS 5/12-4.35)

Sec. 12-4.35. Medical services for certain noncitizens.

(a) Notwithstanding Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act, the Department of Healthcare and Family Services may provide

medical services to noncitizens who have not yet attained 19 years of age and who are not eligible for medical assistance under Article V of this Code or under the Children's Health Insurance Program created by the Children's Health Insurance Program Act due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code or Section 20(a) of the Children's Health Insurance Program Act. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code or the Children's Health Insurance Program created by the Children's Health Insurance Program Act.

(a-5) Notwithstanding Section 1-11 of this Code, the Department of Healthcare and Family Services may provide medical assistance in accordance with Article V of this Code to noncitizens over the age of 65 years of age who are not eligible for medical assistance under Article V of this Code due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code, whose income is at or below 100% of the federal poverty level after deducting the costs of medical or other remedial care, and who would otherwise meet the eligibility requirements in Section 5-2 of this Code. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule

shall be at least as restrictive as the rules for medical assistance under Article V of this Code.

(a-10) Notwithstanding the provisions of Section 1-11, the Department shall cover immunosuppressive drugs and related services associated with post-kidney transplant management, excluding long-term care costs, for noncitizens who: (i) are not eligible for comprehensive medical benefits; (ii) meet the residency requirements of Section 5-3; and (iii) would meet the financial eligibility requirements of Section 5-2.

(b) The Department is authorized to take any action, including without limitation cessation or limitation of enrollment, reduction of available medical services, and changing standards for eligibility, that is deemed necessary by the Department during a State fiscal year to assure that payments under this Section do not exceed available funds.

(c) Continued enrollment of individuals into the program created under subsection (a) of this Section in any fiscal year is contingent upon continued enrollment of individuals into the Children's Health Insurance Program during that fiscal year.

(d) (Blank).

(Source: P.A. 101-636, eff. 6-10-20.)

Article 55.

Section 55-5. The Illinois Public Aid Code is amended by

changing Section 5-5 as follows:

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other

diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

Notwithstanding any other provision of this Section, a comprehensive tobacco use cessation program that includes

purchasing prescription drugs or prescription medical devices approved by the Food and Drug Administration shall be covered under the medical assistance program under this Article for persons who are otherwise eligible for assistance under this Article.

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

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

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department shall authorize the Chicago Public Schools (CPS) to procure a vendor or vendors to manufacture eyeglasses for individuals enrolled in a school within the CPS system. CPS shall ensure that its vendor or vendors are enrolled as providers in the medical assistance program and in any capitated Medicaid managed care entity (MCE) serving individuals enrolled in a school within the CPS system. Under any contract procured

under this provision, the vendor or vendors must serve only individuals enrolled in a school within the CPS system. Claims for services provided by CPS's vendor or vendors to recipients of benefits in the medical assistance program under this Code, the Children's Health Insurance Program, or the Covering ALL KIDS Health Insurance Program shall be submitted to the Department or the MCE in which the individual is enrolled for payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses.

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

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

(2) eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever 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 enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a

process for payment of claims for reimbursement for covered dental services rendered under this provision.

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

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

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

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

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

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

positive genetic testing, or other risk factors.

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

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

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

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

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

For purposes of this Section:

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

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

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

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

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C.

18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

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

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

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

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

program's rates for the data elements included in the breast cancer treatment quality program.

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

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

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

The Department shall establish a performance goal for primary care providers with respect to their female patients

over age 40 receiving an annual mammogram. This performance goal shall be used to provide additional reimbursement in the form of a quality performance bonus to primary care providers who meet that goal.

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

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

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

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

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

to recipients of medical assistance.

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

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

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

The sponsor must negotiate formal written contracts with medical providers for physician services, inpatient and outpatient hospital care, home health services, treatment for

alcoholism and substance abuse, and other services determined necessary by the Illinois Department by rule for delivery by Partnerships. Physician services must include prenatal and obstetrical care. The Illinois Department shall reimburse medical services delivered by Partnership providers to clients in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

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

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

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

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

for participation by medical providers, only with the prior written approval of the Illinois Department.

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

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care

providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after September 16, 1984 (the effective date of Public Act 83-1439), the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that

the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

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

The Illinois Department shall require all dispensers of

medical services, other than an individual practitioner or group of practitioners, desiring to participate in the Medical Assistance program established under this Article to disclose all financial, beneficial, ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services in this State under this Article.

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

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

The Department has the discretion to limit the conditional

enrollment period for vendors based upon category of risk of the vendor.

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

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.

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

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

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

to the Illinois Department within 180 days after the final adjudication by the primary payer.

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

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

To the extent consistent with applicable information and privacy, security, and disclosure laws, State and federal agencies and departments shall provide the Illinois Department access to confidential and other information and data necessary to perform eligibility and payment verifications and

other Illinois Department functions. This includes, but is not limited to: information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

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

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

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

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

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

In order to promote environmental responsibility, meet the needs of recipients and enrollees, and achieve significant cost savings, the Department, or a managed care organization under contract with the Department, may provide recipients or managed care enrollees who have a prescription or Certificate of Medical Necessity access to refurbished durable medical equipment under this Section (excluding prosthetic and orthotic devices as defined in the Orthotics, Prosthetics, and Pedorthics Practice Act and complex rehabilitation technology

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

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and

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

The Illinois Department shall develop and operate, in

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

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

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

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

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

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

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

Library Act.

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

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

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

and the services under this Section shall be limited to services associated with kidney transplantation.

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

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

Upon federal approval, the Department shall provide

coverage and reimbursement for all drugs that are approved for marketing by the federal Food and Drug Administration and that are recommended by the federal Public Health Service or the United States Centers for Disease Control and Prevention for pre-exposure prophylaxis and related pre-exposure prophylaxis services, including, but not limited to, HIV and sexually transmitted infection screening, treatment for sexually transmitted infections, medical monitoring, assorted labs, and counseling to reduce the likelihood of HIV infection among individuals who are not infected with HIV but who are at high risk of HIV infection.

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

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.

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

Section 55-10. The All-Inclusive Care for the Elderly Act is amended by changing Sections 1, 15 and 20 and by adding Sections 6 and 16 as follows:

(320 ILCS 40/1) (from Ch. 23, par. 6901)

Sec. 1. Short title. This Act may be cited as the Program of All-Inclusive Care for the Elderly Act.

(Source: P.A. 87-411.)

(320 ILCS 40/6 new)

Sec. 6. Definitions. As used in this Act:

"Department" means the Department of Healthcare and Family Services.

"PACE organization" means an entity as defined in 42 CFR 460.6.

(320 ILCS 40/15) (from Ch. 23, par. 6915)

Sec. 15. Program implementation.

(a) The Department of Healthcare and Family Services must prepare and submit a PACE State Plan amendment no later than December 31, 2022 to the federal Centers for Medicare and Medicaid Services to establish the Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the Illinois Title XIX State Plan and under contracts entered into between the federal Centers for Medicare and Medicaid Services, the Department of Healthcare and Family Services, and PACE organizations, meeting the requirements of the Balanced Budget Act of 1997 (Public Law 105-33) and any other applicable law or regulation. ~~Upon receipt of federal approval, the Illinois Department of Public Aid (now Department of Healthcare and Family Services) shall implement the PACE program pursuant to the provisions of the approved Title XIX State plan.~~

(b) The Department of Healthcare and Family Services shall facilitate the PACE organization application process no later than December 31, 2023.

(c) All PACE organizations selected shall begin operations no later than June 30, 2024.

(d) ~~(b)~~ Using a risk-based financing model, the organizations contracted to implement ~~nonprofit organization~~

~~providing~~ the PACE program shall assume responsibility for all costs generated by the PACE program participants, and ~~it~~ shall create and maintain a risk reserve fund that will cover any cost overages for any participant. The PACE program is responsible for the entire range of services in the consolidated service model, including hospital and nursing home care, according to participant need as determined by a multidisciplinary team. The contracted organizations are ~~nonprofit organization providing the PACE program is~~ responsible for the full financial risk. Specific arrangements of the risk-based financing model shall be adopted and negotiated by the federal Centers for Medicare and Medicaid Services, the organizations contracted to implement ~~nonprofit organization providing~~ the PACE program, and the Department of Healthcare and Family Services.

(e) The requirements of the PACE model, as provided for under Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act, shall not be waived or modified. The requirements that shall not be waived or modified include all of the following:

(1) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

(2) The delivery of comprehensive, integrated acute and long-term care services.

(3) The interdisciplinary team approach to care

management and service delivery.

(4) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

(5) The assumption by the provider of full financial risk.

(6) The provision of a PACE benefit package for all participants, regardless of source of payment, that shall include all of the following:

(A) All Medicare-covered items and services.

(B) All Medicaid-covered items and services, as specified in the Illinois Title XIX State Plan.

(C) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

(f) The provisions under Sections 1-7 and 5-4 of the Illinois Public Aid Code and under 80 Ill. Adm. Code 120.379, 120.380, and 120.385 shall apply when determining the eligibility for medical assistance of a person receiving PACE services from an organization providing services under this Act.

(g) Provisions governing the treatment of income and resources of a married couple, for the purposes of determining the eligibility of a nursing-facility certifiable or institutionalized spouse, shall be established so as to qualify for federal financial participation.

(h) Notwithstanding subsection (e), and only to the extent federal financial participation is available, the Department of Healthcare and Family Services, in consultation with PACE organizations, may seek increased federal regulatory flexibility from the federal Centers for Medicare and Medicaid Services to modernize the PACE program, which may include, but is not limited to, addressing all of the following:

(A) Composition of PACE interdisciplinary teams.

(B) Use of community-based physicians.

(C) Marketing practices.

(D) Development of a streamlined PACE waiver process.

This subsection shall be operative upon federal approval of a capitation rate methodology as provided under Section 16.

(i) Each PACE organization shall provide the Department with required reporting documents as set forth in 42 CFR 460.190 through 42 CFR 460.196.

(Source: P.A. 94-48, eff. 7-1-05; 95-331, eff. 8-21-07.)

(320 ILCS 40/16 new)

Sec. 16. Rates of payment.

(a) The General Assembly shall make appropriations to the Department to fund services under this Act. The Department shall develop and pay capitation rates to organizations contracted to implement the PACE program as described in Section 15 using actuarial methods.

The Department may develop capitation rates using a

standardized rate methodology across managed care plan models for comparable populations. The specific rate methodology applied to PACE organizations shall address features of PACE that distinguishes it from other managed care plan models.

The rate methodology shall be consistent with actuarial rate development principles and shall provide for all reasonable, appropriate, and attainable costs for each PACE organization within a region.

(b) The Department may develop statewide rates and apply geographic adjustments, using available data sources deemed appropriate by the Department. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its cost and utilization data for the Medical Assistance Program or other data sources as deemed necessary by the Department. Rates developed under this Section shall reflect the level of care associated with the specific populations served under the contract.

(c) The rate methodology developed in accordance with this Section shall contain a mechanism to account for the costs of high-cost drugs and treatments. Rates developed shall be actuarially certified prior to implementation.

(d) Consistent with the requirements of federal law, the Department shall calculate an upper payment limit for payments to PACE organizations. In calculating the upper payment limit, the Department shall collect the applicable data as necessary and shall consider the risk of nursing home placement for the

comparable population when estimating the level of care and risk of PACE participants.

(e) The Department shall pay organizations contracted to implement the PACE program at a rate within the certified actuarially sound rate range developed with respect to that entity as necessary to mitigate the impact to the entity of the methodology developed in accordance with this Section.

(f) This Section shall apply for rates established no earlier than July 1, 2022.

(320 ILCS 40/20) (from Ch. 23, par. 6920)

Sec. 20. Duties of the Department of Healthcare and Family Services.

(a) The Department of Healthcare and Family Services shall provide a system for reimbursement for services to the PACE program.

(b) The Department of Healthcare and Family Services shall develop and implement contracts ~~a contract~~ with organizations as provided in subsection (d) of Section 15 that set ~~the nonprofit organization providing the PACE program that sets~~ forth contractual obligations for the PACE program, including, but not limited to, reporting and monitoring of utilization of costs of the program as required by the Illinois Department.

(c) The Department of Healthcare and Family Services shall acknowledge that it is participating in the national PACE project as initiated by Congress.

(d) The Department of Healthcare and Family Services or its designee shall be responsible for certifying the eligibility for services of all PACE program participants.
(Source: P.A. 95-331, eff. 8-21-07.)

(320 ILCS 40/30 rep.)

Section 55-15. The All-Inclusive Care for the Elderly Act is amended by repealing Section 30.

Article 65.

Section 65-5. The Illinois Public Aid Code is amended by changing Section 5-19 as follows:

(305 ILCS 5/5-19) (from Ch. 23, par. 5-19)

Sec. 5-19. Healthy Kids Program.

(a) Any child under the age of 21 eligible to receive Medical Assistance from the Illinois Department under Article V of this Code shall be eligible for Early and Periodic Screening, Diagnosis and Treatment services provided by the Healthy Kids Program of the Illinois Department under the Social Security Act, 42 U.S.C. 1396d(r).

(b) Enrollment of Children in Medicaid. The Illinois Department shall provide for receipt and initial processing of applications for Medical Assistance for all pregnant women and children under the age of 21 at locations in addition to those

used for processing applications for cash assistance, including disproportionate share hospitals, federally qualified health centers and other sites as selected by the Illinois Department.

(c) Healthy Kids Examinations. The Illinois Department shall consider any examination of a child eligible for the Healthy Kids services provided by a medical provider meeting the requirements and complying with the rules and regulations of the Illinois Department to be reimbursed as a Healthy Kids examination.

(d) Medical Screening Examinations.

(1) The Illinois Department shall insure Medicaid coverage for periodic health, vision, hearing, and dental screenings for children eligible for Healthy Kids services scheduled from a child's birth up until the child turns 21 years. The Illinois Department shall pay for vision, hearing, dental and health screening examinations for any child eligible for Healthy Kids services by qualified providers at intervals established by Department rules.

(2) The Illinois Department shall pay for an interperiodic health, vision, hearing, or dental screening examination for any child eligible for Healthy Kids services whenever an examination is:

(A) requested by a child's parent, guardian, or custodian, or is determined to be necessary or appropriate by social services, developmental, health,

or educational personnel; or

(B) necessary for enrollment in school; or

(C) necessary for enrollment in a licensed day care program, including Head Start; or

(D) necessary for placement in a licensed child welfare facility, including a foster home, group home or child care institution; or

(E) necessary for attendance at a camping program; or

(F) necessary for participation in an organized athletic program; or

(G) necessary for enrollment in an early childhood education program recognized by the Illinois State Board of Education; or

(H) necessary for participation in a Women, Infant, and Children (WIC) program; or

(I) deemed appropriate by the Illinois Department.

(e) Minimum Screening Protocols For Periodic Health Screening Examinations. Health Screening Examinations must include the following services:

(1) Comprehensive Health and Development Assessment including:

(A) Development/Mental Health/Psychosocial Assessment; and

(B) Assessment of nutritional status including tests for iron deficiency and anemia for children at

the following ages: 9 months, 2 years, 8 years, and 18 years;

(2) Comprehensive unclothed physical exam;

(3) Appropriate immunizations at a minimum, as required by the Secretary of the U.S. Department of Health and Human Services under 42 U.S.C. 1396d(r).

(4) Appropriate laboratory tests including blood lead levels appropriate for age and risk factors.

(A) Anemia test.

(B) Sickle cell test.

(C) Tuberculin test at 12 months of age and every 1-2 years thereafter unless the treating health care professional determines that testing is medically contraindicated.

(D) Other -- The Illinois Department shall insure that testing for HIV, drug exposure, and sexually transmitted diseases is provided for as clinically indicated.

(5) Health Education. The Illinois Department shall require providers to provide anticipatory guidance as recommended by the American Academy of Pediatrics.

(6) Vision Screening. The Illinois Department shall require providers to provide vision screenings consistent with those set forth in the Department of Public Health's Administrative Rules.

(7) Hearing Screening. The Illinois Department shall

require providers to provide hearing screenings consistent with those set forth in the Department of Public Health's Administrative Rules.

(8) Dental Screening. The Illinois Department shall require providers to provide dental screenings consistent with those set forth in the Department of Public Health's Administrative Rules.

(f) Covered Medical Services. The Illinois Department shall provide coverage for all necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects, physical and mental illnesses, and conditions whether discovered by the screening services or not for all children eligible for Medical Assistance under Article V of this Code.

(g) Notice of Healthy Kids Services.

(1) The Illinois Department shall inform any child eligible for Healthy Kids services and the child's family about the benefits provided under the Healthy Kids Program, including, but not limited to, the following: what services are available under Healthy Kids, including discussion of the periodicity schedules and immunization schedules, that services are provided at no cost to eligible children, the benefits of preventive health care, where the services are available, how to obtain them, and that necessary transportation and scheduling assistance is available.

(2) The Illinois Department shall widely disseminate information regarding the availability of the Healthy Kids Program throughout the State by outreach activities which shall include, but not be limited to, (i) the development of cooperation agreements with local school districts, public health agencies, clinics, hospitals and other health care providers, including developmental disability and mental health providers, and with charities, to notify the constituents of each of the Program and assist individuals, as feasible, with applying for the Program, (ii) using the media for public service announcements and advertisements of the Program, and (iii) developing posters advertising the Program for display in hospital and clinic waiting rooms.

(3) The Illinois Department shall utilize accepted methods for informing persons who are illiterate, blind, deaf, or cannot understand the English language, including but not limited to public services announcements and advertisements in the foreign language media of radio, television and newspapers.

(4) The Illinois Department shall provide notice of the Healthy Kids Program to every child eligible for Healthy Kids services and his or her family at the following times:

(A) orally by the intake worker and in writing at the time of application for Medical Assistance;

(B) at the time the applicant is informed that he or she is eligible for Medical Assistance benefits; and

(C) at least 20 days before the date of any periodic health, vision, hearing, and dental examination for any child eligible for Healthy Kids services. Notice given under this subparagraph (C) must state that a screening examination is due under the periodicity schedules and must advise the eligible child and his or her family that the Illinois Department will provide assistance in scheduling an appointment and arranging medical transportation.

(h) Data Collection. The Illinois Department shall collect data in a usable form to track utilization of Healthy Kids screening examinations by children eligible for Healthy Kids services, including but not limited to data showing screening examinations and immunizations received, a summary of follow-up treatment received by children eligible for Healthy Kids services and the number of children receiving dental, hearing and vision services.

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

(j) To ensure full access to the benefits set forth in this

Section, on and after January 1, 2022, the Illinois Department shall ensure that provider and hospital reimbursements for immunization as required under this Section are no lower than 70% of the median regional maximum administration fee for the State of Illinois as established by the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services.

(Source: P.A. 97-689, eff. 6-14-12.)

Article 70.

Section 70-5. The Illinois Public Aid Code is amended by changing Section 5-5.01a as follows:

(305 ILCS 5/5-5.01a)

Sec. 5-5.01a. Supportive living facilities program.

(a) The Department shall establish and provide oversight for a program of supportive living facilities that seek to promote resident independence, dignity, respect, and well-being in the most cost-effective manner.

A supportive living facility is (i) a free-standing facility or (ii) a distinct physical and operational entity within a mixed-use building that meets the criteria established in subsection (d). A supportive living facility integrates housing with health, personal care, and supportive services and is a designated setting that offers residents

their own separate, private, and distinct living units.

Sites for the operation of the program shall be selected by the Department based upon criteria that may include the need for services in a geographic area, the availability of funding, and the site's ability to meet the standards.

(b) Beginning July 1, 2014, subject to federal approval, the Medicaid rates for supportive living facilities shall be equal to the supportive living facility Medicaid rate effective on June 30, 2014 increased by 8.85%. Once the assessment imposed at Article V-G of this Code is determined to be a permissible tax under Title XIX of the Social Security Act, the Department shall increase the Medicaid rates for supportive living facilities effective on July 1, 2014 by 9.09%. The Department shall apply this increase retroactively to coincide with the imposition of the assessment in Article V-G of this Code in accordance with the approval for federal financial participation by the Centers for Medicare and Medicaid Services.

The Medicaid rates for supportive living facilities effective on July 1, 2017 must be equal to the rates in effect for supportive living facilities on June 30, 2017 increased by 2.8%.

Subject to federal approval, the Medicaid rates for supportive living services on and after July 1, 2019 must be at least 54.3% of the average total nursing facility services per diem for the geographic areas defined by the Department while

maintaining the rate differential for dementia care and must be updated whenever the total nursing facility service per diems are updated.

(c) The Department may adopt rules to implement this Section. Rules that establish or modify the services, standards, and conditions for participation in the program shall be adopted by the Department in consultation with the Department on Aging, the Department of Rehabilitation Services, and the Department of Mental Health and Developmental Disabilities (or their successor agencies).

(d) Subject to federal approval by the Centers for Medicare and Medicaid Services, the Department shall accept for consideration of certification under the program any application for a site or building where distinct parts of the site or building are designated for purposes other than the provision of supportive living services, but only if:

(1) those distinct parts of the site or building are not designated for the purpose of providing assisted living services as required under the Assisted Living and Shared Housing Act;

(2) those distinct parts of the site or building are completely separate from the part of the building used for the provision of supportive living program services, including separate entrances;

(3) those distinct parts of the site or building do not share any common spaces with the part of the building

used for the provision of supportive living program services; and

(4) those distinct parts of the site or building do not share staffing with the part of the building used for the provision of supportive living program services.

(e) Facilities or distinct parts of facilities which are selected as supportive living facilities and are in good standing with the Department's rules are exempt from the provisions of the Nursing Home Care Act and the Illinois Health Facilities Planning Act.

(f) Section 9817 of the American Rescue Plan Act of 2021 (Public Law 117-2) authorizes a 10% enhanced federal medical assistance percentage for supportive living services for a 12-month period from April 1, 2021 through March 31, 2022. Subject to federal approval, including the approval of any necessary waiver amendments or other federally required documents or assurances, for a 12-month period the Department must pay a supplemental $26 per diem rate to all supportive living facilities with the additional federal financial participation funds that result from the enhanced federal medical assistance percentage from April 1, 2021 through March 31, 2022. The Department may issue parameters around how the supplemental payment should be spent, including quality improvement activities. The Department may alter the form, methods, or timeframes concerning the supplemental per diem rate to comply with any subsequent changes to federal law,

changes made by guidance issued by the federal Centers for Medicare and Medicaid Services, or other changes necessary to receive the enhanced federal medical assistance percentage.

(Source: P.A. 100-23, eff. 7-6-17; 100-583, eff. 4-6-18; 100-587, eff. 6-4-18; 101-10, eff. 6-5-19.)

Article 75.

Section 75-5. The Illinois Health Information Exchange and Technology Act is amended by adding Section 997 as follows:

(20 ILCS 3860/997 new)

Sec. 997. Repealer. This Act is repealed on January 1, 2027.

Article 80.

Section 80-5. The Illinois Public Aid Code is amended by changing Section 5-5f as follows:

(305 ILCS 5/5-5f)

Sec. 5-5f. Elimination and limitations of medical assistance services. Notwithstanding any other provision of this Code to the contrary, on and after July 1, 2012:

(a) The following services shall no longer be a covered service available under this Code: group

psychotherapy for residents of any facility licensed under the Nursing Home Care Act or the Specialized Mental Health Rehabilitation Act of 2013; and adult chiropractic services.

(b) The Department shall place the following limitations on services: (i) the Department shall limit adult eyeglasses to one pair every 2 years; however, the limitation does not apply to an individual who needs different eyeglasses following a surgical procedure such as cataract surgery; (ii) the Department shall set an annual limit of a maximum of 20 visits for each of the following services: adult speech, hearing, and language therapy services, adult occupational therapy services, and physical therapy services; on or after October 1, 2014, the annual maximum limit of 20 visits shall expire but the Department may require prior approval for all individuals for speech, hearing, and language therapy services, occupational therapy services, and physical therapy services; (iii) the Department shall limit adult podiatry services to individuals with diabetes; on or after October 1, 2014, podiatry services shall not be limited to individuals with diabetes; (iv) the Department shall pay for caesarean sections at the normal vaginal delivery rate unless a caesarean section was medically necessary; (v) the Department shall limit adult dental services to emergencies; beginning July 1, 2013, the Department shall

ensure that the following conditions are recognized as emergencies: (A) dental services necessary for an individual in order for the individual to be cleared for a medical procedure, such as a transplant; (B) extractions and dentures necessary for a diabetic to receive proper nutrition; (C) extractions and dentures necessary as a result of cancer treatment; and (D) dental services necessary for the health of a pregnant woman prior to delivery of her baby; on or after July 1, 2014, adult dental services shall no longer be limited to emergencies, and dental services necessary for the health of a pregnant woman prior to delivery of her baby shall continue to be covered; and (vi) effective July 1, 2012, the Department shall place limitations and require concurrent review on every inpatient detoxification stay to prevent repeat admissions to any hospital for detoxification within 60 days of a previous inpatient detoxification stay. The Department shall convene a workgroup of hospitals, substance abuse providers, care coordination entities, managed care plans, and other stakeholders to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification, which shall be published on the Department's website no later than September 1, 2013.

(c) The Department shall require prior approval of the following services: wheelchair repairs costing more than

$750 ~~$400~~, coronary artery bypass graft, and bariatric surgery consistent with Medicare standards concerning patient responsibility. Wheelchair repair prior approval requests shall be adjudicated within one business day of receipt of complete supporting documentation. Providers may not break wheelchair repairs into separate claims for purposes of staying under the $750 ~~$400~~ threshold for requiring prior approval. The wholesale price of manual and power wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

(d) The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a

minimum, $40,000,000.

(e) The Department shall establish utilization controls for the hospice program such that it shall not pay for other care services when an individual is in hospice.

(f) For home health services, the Department shall require Medicare certification of providers participating in the program and implement the Medicare face-to-face encounter rule. The Department shall require providers to implement auditable electronic service verification based on global positioning systems or other cost-effective technology.

(g) For the Home Services Program operated by the Department of Human Services and the Community Care Program operated by the Department on Aging, the Department of Human Services, in cooperation with the Department on Aging, shall implement an electronic service verification based on global positioning systems or other cost-effective technology.

(h) Effective with inpatient hospital admissions on or after July 1, 2012, the Department shall reduce the payment for a claim that indicates the occurrence of a provider-preventable condition during the admission as specified by the Department in rules. The Department shall not pay for services related to an other provider-preventable condition.

As used in this subsection (h):

"Provider-preventable condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 or an other provider-preventable condition.

"Other provider-preventable condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

(i) The Department shall implement cost savings initiatives for advanced imaging services, cardiac imaging services, pain management services, and back surgery. Such initiatives shall be designed to achieve annual costs savings.

(j) The Department shall ensure that beneficiaries with a diagnosis of epilepsy or seizure disorder in Department records will not require prior approval for anticonvulsants.

(Source: P.A. 100-135, eff. 8-18-17; 101-209, eff. 8-5-19.)

Article 85.

Section 85-5. The School Code is amended by changing Section 14-15.01 as follows:

(105 ILCS 5/14-15.01) (from Ch. 122, par. 14-15.01)

Sec. 14-15.01. Community and Residential Services Authority.

(a) (1) The Community and Residential Services Authority is hereby created and shall consist of the following members:

A representative of the State Board of Education;

Four representatives of the Department of Human Services appointed by the Secretary of Human Services, with one member from the Division of Community Health and Prevention, one member from the Division of Developmental Disabilities, one member from the Division of Mental Health, and one member from the Division of Rehabilitation Services;

A representative of the Department of Children and Family Services;

A representative of the Department of Juvenile Justice;

A representative of the Department of Healthcare and Family Services;

A representative of the Attorney General's Disability Rights Advocacy Division;

The Chairperson and Minority Spokesperson of the House and Senate Committees on Elementary and Secondary Education or their designees; and

Six persons appointed by the Governor. Five of such appointees shall be experienced or knowledgeable relative to provision of services for individuals with a behavior disorder or a severe emotional disturbance and shall include

representatives of both the private and public sectors, except that no more than 2 of those 5 appointees may be from the public sector and at least 2 must be or have been directly involved in provision of services to such individuals. The remaining member appointed by the Governor shall be or shall have been a parent of an individual with a behavior disorder or a severe emotional disturbance, and that appointee may be from either the private or the public sector.

(2) Members appointed by the Governor shall be appointed for terms of 4 years and shall continue to serve until their respective successors are appointed; provided that the terms of the original appointees shall expire on August 1, 1990. Any vacancy in the office of a member appointed by the Governor shall be filled by appointment of the Governor for the remainder of the term.

A vacancy in the office of a member appointed by the Governor exists when one or more of the following events occur:

(i) An appointee dies;

(ii) An appointee files a written resignation with the Governor;

(iii) An appointee ceases to be a legal resident of the State of Illinois; or

(iv) An appointee fails to attend a majority of regularly scheduled Authority meetings in a fiscal year.

Members who are representatives of an agency shall serve

at the will of the agency head. Membership on the Authority shall cease immediately upon cessation of their affiliation with the agency. If such a vacancy occurs, the appropriate agency head shall appoint another person to represent the agency.

If a legislative member of the Authority ceases to be Chairperson or Minority Spokesperson of the designated Committees, they shall automatically be replaced on the Authority by the person who assumes the position of Chairperson or Minority Spokesperson.

(b) The Community and Residential Services Authority shall have the following powers and duties:

(1) To conduct surveys to determine the extent of need, the degree to which documented need is currently being met and feasible alternatives for matching need with resources.

(2) To develop policy statements for interagency cooperation to cover all aspects of service delivery, including laws, regulations and procedures, and clear guidelines for determining responsibility at all times.

(3) To recommend policy statements and provide information regarding effective programs for delivery of services to all individuals under 22 years of age with a behavior disorder or a severe emotional disturbance in public or private situations.

(4) To review the criteria for service eligibility,

provision and availability established by the governmental agencies represented on this Authority, and to recommend changes, additions or deletions to such criteria.

(5) To develop and submit to the Governor, the General Assembly, the Directors of the agencies represented on the Authority, and the State Board of Education a master plan for individuals under 22 years of age with a behavior disorder or a severe emotional disturbance, including detailed plans of service ranging from the least to the most restrictive options; and to assist local communities, upon request, in developing or strengthening collaborative interagency networks.

(6) To develop a process for making determinations in situations where there is a dispute relative to a plan of service for individuals or funding for a plan of service.

(7) To provide technical assistance to parents, service consumers, providers, and member agency personnel regarding statutory responsibilities of human service and educational agencies, and to provide such assistance as deemed necessary to appropriately access needed services.

(8) To establish a pilot program to act as a residential research hub to research and identify appropriate residential settings for youth who are being housed in an emergency room for more than 72 hours or who are deemed beyond medical necessity in a psychiatric hospital. If a child is deemed beyond medical necessity in

a psychiatric hospital and is in need of residential placement, the goal of the program is to prevent a lock-out pursuant to the goals of the Custody Relinquishment Prevention Act.

(c) (1) The members of the Authority shall receive no compensation for their services but shall be entitled to reimbursement of reasonable expenses incurred while performing their duties.

(2) The Authority may appoint special study groups to operate under the direction of the Authority and persons appointed to such groups shall receive only reimbursement of reasonable expenses incurred in the performance of their duties.

(3) The Authority shall elect from its membership a chairperson, vice-chairperson and secretary.

(4) The Authority may employ and fix the compensation of such employees and technical assistants as it deems necessary to carry out its powers and duties under this Act. Staff assistance for the Authority shall be provided by the State Board of Education.

(5) Funds for the ordinary and contingent expenses of the Authority shall be appropriated to the State Board of Education in a separate line item.

(d) (1) The Authority shall have power to promulgate rules and regulations to carry out its powers and duties under this Act.

(2) The Authority may accept monetary gifts or grants from the federal government or any agency thereof, from any charitable foundation or professional association or from any other reputable source for implementation of any program necessary or desirable to the carrying out of the general purposes of the Authority. Such gifts and grants may be held in trust by the Authority and expended in the exercise of its powers and performance of its duties as prescribed by law.

(3) The Authority shall submit an annual report of its activities and expenditures to the Governor, the General Assembly, the directors of agencies represented on the Authority, and the State Superintendent of Education.

(e) The Executive Director of the Authority or his or her designee shall be added as a participant on the Interagency Clinical Team established in the intergovernmental agreement among the Department of Healthcare and Family Services, the Department of Children and Family Services, the Department of Human Services, the State Board of Education, the Department of Juvenile Justice, and the Department of Public Health, with consent of the youth or the youth's guardian or family pursuant to the Custody Relinquishment Prevention Act.

(Source: P.A. 95-331, eff. 8-21-07; 95-793, eff. 1-1-09.)

Article 90.

Section 90-5. The Illinois Public Aid Code is amended by

adding Section 5-43 as follows:

(305 ILCS 5/5-43 new)

Sec. 5-43. Supports Waiver Program for Young Adults with Developmental Disabilities.

(a) The Department of Human Services' Division of Developmental Disabilities, in partnership with the Department of Healthcare and Family Services and stakeholders, shall study the development and implementation of a supports waiver program for young adults with developmental disabilities. The Division shall explore the following components of a supports waiver program to determine what is most appropriate:

(1) The age of individuals to be provided services in a waiver program.

(2) The number of individuals to be provided services in a waiver program.

(3) The services to be provided in a waiver program.

(4) The funding to be provided to individuals within a waiver program.

(5) The transition process to the Waiver for Adults with Developmental Disabilities.

(6) The type of home and community-based services waiver to be utilized.

(b) The Department of Human Services and the Department of Healthcare and Family Services are authorized to adopt and implement any rules necessary to study the supports waiver

program.

(c) Subject to appropriation, no later than January 1, 2024, the Department of Healthcare and Family Services shall apply to the federal Centers for Medicare and Medicaid Services for a supports waiver for young adults with developmental disabilities utilizing the information learned from the study under subsection (a).

Article 95.

Section 95-5. The Illinois Public Aid Code is amended by adding Section 5-5.06a as follows:

(305 ILCS 5/5-5.06a new)

Sec. 5-5.06a. Increased funding for dental services. Beginning January 1, 2022, the amount allocated to fund rates for dental services provided to adults and children under the medical assistance program shall be increased by an approximate amount of $10,000,000.

Article 105.

Section 105-5. The Illinois Public Aid Code is amended by changing Section 5-30.1 as follows:

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

"Managed care organization" or "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

"Emergency services" include:

(1) emergency services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(2) emergency medical screening examinations, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(3) post-stabilization medical services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act; and

(4) emergency medical conditions, as defined by Section 10 of the Managed Care Reform and Patient Rights Act.

(b) As provided by Section 5-16.12, managed care organizations are subject to the provisions of the Managed Care Reform and Patient Rights Act.

(c) An MCO shall pay any provider of emergency services that does not have in effect a contract with the contracted Medicaid MCO. The default rate of reimbursement shall be the rate paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid

Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates.

(d) An MCO shall pay for all post-stabilization services as a covered service in any of the following situations:

(1) the MCO authorized such services;

(2) such services were administered to maintain the enrollee's stabilized condition within one hour after a request to the MCO for authorization of further post-stabilization services;

(3) the MCO did not respond to a request to authorize such services within one hour;

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited

to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

(e) The following requirements apply to MCOs in determining payment for all emergency services:

(1) MCOs shall not impose any requirements for prior approval of emergency services.

(2) The MCO shall cover emergency services provided to enrollees who are temporarily away from their residence and outside the contracting area to the extent that the enrollees would be entitled to the emergency services if they still were within the contracting area.

(3) The MCO shall have no obligation to cover medical services provided on an emergency basis that are not covered services under the contract.

(4) The MCO shall not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's screening and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the provider actually treating the enrollee, of whether an enrollee is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover emergency services

for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider.

(6) The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

(A) a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(B) a plan physician assumes responsibility for the enrollee's care through transfer;

(C) a contracting entity representative and the treating physician reach an agreement concerning the enrollee's care; or

(D) the enrollee is discharged.

(f) Network adequacy and transparency.

(1) The Department shall:

(A) ensure that an adequate provider network is in place, taking into consideration health professional shortage areas and medically underserved areas;

(B) publicly release an explanation of its process for analyzing network adequacy;

(C) periodically ensure that an MCO continues to have an adequate network in place;

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3;

and

(E) require MCOs to ensure that any Medicaid-certified provider under contract with an MCO and previously submitted on a roster on the date of service is paid for any medically necessary, Medicaid-covered, and authorized service rendered to any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available directory of available providers.

(2) Each MCO shall confirm its receipt of information submitted specific to physician or dentist additions or physician or dentist deletions from the MCO's provider network within 3 days after receiving all required information from contracted physicians or dentists, and electronic physician and dental directories must be updated consistent with current rules as published by the Centers for Medicare and Medicaid Services or its successor agency.

(g) Timely payment of claims.

(1) The MCO shall pay a claim within 30 days of receiving a claim that contains all the essential information needed to adjudicate the claim.

(2) The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.

(3) The MCO shall pay a penalty that is at least equal

to the timely payment interest penalty imposed under Section 368a of the Illinois Insurance Code for any claims not timely paid.

(A) When an MCO is required to pay a timely payment interest penalty to a provider, the MCO must calculate and pay the timely payment interest penalty that is due to the provider within 30 days after the payment of the claim. In no event shall a provider be required to request or apply for payment of any owed timely payment interest penalties.

(B) Such payments shall be reported separately from the claim payment for services rendered to the MCO's enrollee and clearly identified as interest payments.

(4)(A) The Department shall require MCOs to expedite payments to providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), on a schedule at least as frequently as the providers are paid under the Department's fee-for-service expedited provider schedule.

(B) Compliance with the expedited provider requirement may be satisfied by an MCO through the use of a Periodic Interim Payment (PIP) program that has been mutually agreed to and documented between the MCO and the provider, if the PIP program ensures that any expedited provider receives regular and periodic payments based on prior

period payment experience from that MCO. Total payments under the PIP program may be reconciled against future PIP payments on a schedule mutually agreed to between the MCO and the provider.

(C) The Department shall share at least monthly its expedited provider list and the frequency with which it pays providers on the expedited list.

(g-5) Recognizing that the rapid transformation of the Illinois Medicaid program may have unintended operational challenges for both payers and providers:

(1) in no instance shall a medically necessary covered service rendered in good faith, based upon eligibility information documented by the provider, be denied coverage or diminished in payment amount if the eligibility or coverage information available at the time the service was rendered is later found to be inaccurate in the assignment of coverage responsibility between MCOs or the fee-for-service system, except for instances when an individual is deemed to have not been eligible for coverage under the Illinois Medicaid program; and

(2) the Department shall, by December 31, 2016, adopt rules establishing policies that shall be included in the Medicaid managed care policy and procedures manual addressing payment resolutions in situations in which a provider renders services based upon information obtained after verifying a patient's eligibility and coverage plan

through either the Department's current enrollment system or a system operated by the coverage plan identified by the patient presenting for services:

(A) such medically necessary covered services shall be considered rendered in good faith;

(B) such policies and procedures shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

The rules shall be applicable for both MCO coverage and fee-for-service coverage.

If the fee-for-service system is ultimately determined to have been responsible for coverage on the date of service, the Department shall provide for an extended period for claims submission outside the standard timely filing requirements.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

(2) The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(3) The metrics shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the

applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims. ~~The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.~~

(g-8) Dispute resolution process. The Department shall maintain a provider complaint portal through which a provider can submit to the Department unresolved disputes with an MCO. An unresolved dispute means an MCO's decision that denies in whole or in part a claim for reimbursement to a provider for health care services rendered by the provider to an enrollee of the MCO with which the provider disagrees. Disputes shall not be submitted to the portal until the provider has availed itself of the MCO's internal dispute resolution process. Disputes that are submitted to the MCO internal dispute

resolution process may be submitted to the Department of Healthcare and Family Services' complaint portal no sooner than 30 days after submitting to the MCO's internal process and not later than 30 days after the unsatisfactory resolution of the internal MCO process or 60 days after submitting the dispute to the MCO internal process. Multiple claim disputes involving the same MCO may be submitted in one complaint, regardless of whether the claims are for different enrollees, when the specific reason for non-payment of the claims involves a common question of fact or policy. Within 10 business days of receipt of a complaint, the Department shall present such disputes to the appropriate MCO, which shall then have 30 days to issue its written proposal to resolve the dispute. The Department may grant one 30-day extension of this time frame to one of the parties to resolve the dispute. If the dispute remains unresolved at the end of this time frame or the provider is not satisfied with the MCO's written proposal to resolve the dispute, the provider may, within 30 days, request the Department to review the dispute and make a final determination. Within 30 days of the request for Department review of the dispute, both the provider and the MCO shall present all relevant information to the Department for resolution and make individuals with knowledge of the issues available to the Department for further inquiry if needed. Within 30 days of receiving the relevant information on the dispute, or the lapse of the period for submitting such

information, the Department shall issue a written decision on the dispute based on contractual terms between the provider and the MCO, contractual terms between the MCO and the Department of Healthcare and Family Services and applicable Medicaid policy. The decision of the Department shall be final. By January 1, 2020, the Department shall establish by rule further details of this dispute resolution process. Disputes between MCOs and providers presented to the Department for resolution are not contested cases, as defined in Section 1-30 of the Illinois Administrative Procedure Act, conferring any right to an administrative hearing.

(g-9)(1) The Department shall publish annually on its website a report on the calculation of each managed care organization's medical loss ratio showing the following:

(A) Premium revenue, with appropriate adjustments.

(B) Benefit expense, setting forth the aggregate amount spent for the following:

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

(vi) Expenses for activities that improve health care quality as allowed by the Department.

(2) The medical loss ratio shall be calculated consistent with federal law and regulation following a claims runout

period determined by the Department.

(g-10)(1) "Liability effective date" means the date on which an MCO becomes responsible for payment for medically necessary and covered services rendered by a provider to one of its enrollees in accordance with the contract terms between the MCO and the provider. The liability effective date shall be the later of:

(A) The execution date of a network participation contract agreement.

(B) The date the provider or its representative submits to the MCO the complete and accurate standardized roster form for the provider in the format approved by the Department.

(C) The provider effective date contained within the Department's provider enrollment subsystem within the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) System.

(2) The standardized roster form may be submitted to the MCO at the same time that the provider submits an enrollment application to the Department through IMPACT.

(3) By October 1, 2019, the Department shall require all MCOs to update their provider directory with information for new practitioners of existing contracted providers within 30 days of receipt of a complete and accurate standardized roster template in the format approved by the Department provided that the provider is effective in the Department's provider

enrollment subsystem within the IMPACT system. Such provider directory shall be readily accessible for purposes of selecting an approved health care provider and comply with all other federal and State requirements.

(g-11) The Department shall work with relevant stakeholders on the development of operational guidelines to enhance and improve operational performance of Illinois' Medicaid managed care program, including, but not limited to, improving provider billing practices, reducing claim rejections and inappropriate payment denials, and standardizing processes, procedures, definitions, and response timelines, with the goal of reducing provider and MCO administrative burdens and conflict. The Department shall include a report on the progress of these program improvements and other topics in its Fiscal Year 2020 annual report to the General Assembly.

(g-12) Notwithstanding any other provision of law, if the Department or an MCO requires submission of a claim for payment in a non-electronic format, a provider shall always be afforded a period of no less than 90 business days, as a correction period, following any notification of rejection by either the Department or the MCO to correct errors or omissions in the original submission.

Under no circumstances, either by an MCO or under the State's fee-for-service system, shall a provider be denied payment for failure to comply with any timely submission

requirements under this Code or under any existing contract, unless the non-electronic format claim submission occurs after the initial 180 days following the latest date of service on the claim, or after the 90 business days correction period following notification to the provider of rejection or denial of payment.

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(j) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form that grants to the health care provider

permission to release the recipient's health care information to the recipient's insurance carrier.

(k) The Department of Healthcare and Family Services, managed care organizations, a statewide organization representing hospitals, and a statewide organization representing safety-net hospitals shall explore ways to support billing departments in safety-net hospitals.

(l) The requirements of this Section added by this amendatory Act of the 102nd General Assembly shall apply to services provided on or after the first day of the month that begins 60 days after the effective date of this amendatory Act of the 102nd General Assembly.

(Source: P.A. 101-209, eff. 8-5-19; 102-4, eff. 4-27-21.)

Article 999.

Section 999-99. Effective date. This Act takes effect upon becoming law.