

1 AN ACT concerning regulation.

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

4 Article 3.

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

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

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

19 As part of the Strategy development process, by January 1,
20 2022 the Department of Healthcare and Family Services shall
21 establish a program for the implementation of certified
22 community behavioral health clinics. Behavioral health
23 services providers that received federal grant funding from
24 SAMHSA for the implementation of certified community
25 behavioral health clinics prior to July 1, 2021 shall be
26 eligible to participate in the program established in

1 accordance with this Section.

2 Article 5.

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

5 (305 ILCS 5/5-5f)

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

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

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

1 physical therapy services; on or after October 1, 2014,
2 the annual maximum limit of 20 visits shall expire but the
3 Department may require prior approval for all individuals
4 for speech, hearing, and language therapy services,
5 occupational therapy services, and physical therapy
6 services; (iii) the Department shall limit adult podiatry
7 services to individuals with diabetes; on or after October
8 1, 2014, podiatry services shall not be limited to
9 individuals with diabetes; (iv) the Department shall pay
10 for caesarean sections at the normal vaginal delivery rate
11 unless a caesarean section was medically necessary; (v)
12 the Department shall limit adult dental services to
13 emergencies; beginning July 1, 2013, the Department shall
14 ensure that the following conditions are recognized as
15 emergencies: (A) dental services necessary for an
16 individual in order for the individual to be cleared for a
17 medical procedure, such as a transplant; (B) extractions
18 and dentures necessary for a diabetic to receive proper
19 nutrition; (C) extractions and dentures necessary as a
20 result of cancer treatment; and (D) dental services
21 necessary for the health of a pregnant woman prior to
22 delivery of her baby; on or after July 1, 2014, adult
23 dental services shall no longer be limited to emergencies,
24 and dental services necessary for the health of a pregnant
25 woman prior to delivery of her baby shall continue to be
26 covered; and (vi) effective July 1, 2012 through June 30,

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

13 (c) The Department shall require prior approval of the
14 following services: wheelchair repairs costing more than
15 \$400, coronary artery bypass graft, and bariatric surgery
16 consistent with Medicare standards concerning patient
17 responsibility. Wheelchair repair prior approval requests
18 shall be adjudicated within one business day of receipt of
19 complete supporting documentation. Providers may not break
20 wheelchair repairs into separate claims for purposes of
21 staying under the \$400 threshold for requiring prior
22 approval. The wholesale price of manual and power
23 wheelchairs, durable medical equipment and supplies, and
24 complex rehabilitation technology products and services
25 shall be defined as actual acquisition cost including all
26 discounts.

1 (d) The Department shall establish benchmarks for
2 hospitals to measure and align payments to reduce
3 potentially preventable hospital readmissions, inpatient
4 complications, and unnecessary emergency room visits. In
5 doing so, the Department shall consider items, including,
6 but not limited to, historic and current acuity of care
7 and historic and current trends in readmission. The
8 Department shall publish provider-specific historical
9 readmission data and anticipated potentially preventable
10 targets 60 days prior to the start of the program. In the
11 instance of readmissions, the Department shall adopt
12 policies and rates of reimbursement for services and other
13 payments provided under this Code to ensure that, by June
14 30, 2013, expenditures to hospitals are reduced by, at a
15 minimum, \$40,000,000.

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

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

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

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

15 As used in this subsection (h):

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

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

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

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

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

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

9 (305 ILCS 5/5-41 new)

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

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

9 Article 10.

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

12 (305 ILCS 5/5-8) (from Ch. 23, par. 5-8)

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

1 recognized under State law, (iv) persons licensed under other
2 laws of this State as a clinical social worker, and (v) persons
3 licensed under other laws of this State as physician
4 assistants. The Department shall adopt rules, no later than 90
5 days after January 1, 2017 (the effective date of Public Act
6 99-621), for the legally authorized services of persons
7 licensed under other laws of this State as a clinical social
8 worker. The Department shall provide for the legally
9 authorized services of persons licensed under the Professional
10 Counselor and Clinical Professional Counselor Licensing and
11 Practice Act as clinical professional counselors and for the
12 legally authorized services of persons licensed under the
13 Marriage and Family Therapy Licensing Act as marriage and
14 family therapists. The utilization of the services of persons
15 engaged in the treatment or care of the sick, which persons are
16 not required to be licensed or registered under the laws of
17 this State, is not prohibited by this Section.

18 (Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17;
19 100-453, eff. 8-25-17; 100-513, eff. 1-1-18; 100-538, eff.
20 1-1-18; 100-863, eff. 8-14-18.)

21 Article 15.

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

1 (20 ILCS 2205/2205-35 new)

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

9 Article 20.

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

12 (305 ILCS 5/5-5.4k new)

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

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

7 Article 25.

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

10 (5 ILCS 100/5-45.8 new)

11 Sec. 5-45.8. Emergency rulemaking; Medicaid eligibility
12 expansion. To provide for the expeditious and timely
13 implementation of the changes made to paragraph 6 of Section
14 5-2 of the Illinois Public Aid Code by this amendatory Act of
15 the 102nd General Assembly, emergency rules implementing the
16 changes made to paragraph 6 of Section 5-2 of the Illinois
17 Public Aid Code by this amendatory Act of the 102nd General
18 Assembly may be adopted in accordance with Section 5-45 by the
19 Department of Healthcare and Family Services. The adoption of
20 emergency rules authorized by Section 5-45 and this Section is
21 deemed to be necessary for the public interest, safety, and
22 welfare.

23 This Section is repealed on January 1, 2027.

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

3 (215 ILCS 106/6 new)

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

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

15 (215 ILCS 170/6 new)

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

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

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

6 (305 ILCS 5/5-1.5)

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

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

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

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

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

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

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

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

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

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

25 (i) their income, as determined by the

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

4 (ii) their income, after the deduction of
5 costs incurred for medical care and for other
6 types of remedial care, is equal to or less than
7 100% of the federal poverty level.

8 (b) (Blank).

9 3. (Blank).

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

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

1 rule, is equal to or less than the Medical Assistance-No
2 Grant(C) (MANG(C)) Income Standard in effect on April 1,
3 2013 as set forth in administrative rule.

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

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

23 6. (a) Subject to federal approval, children ~~Children~~
24 younger than age 19 when countable income is at or below
25 313% ~~133%~~ of the federal poverty level, as determined by
26 the Department and in accordance with all applicable

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

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

19 7. (Blank).

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

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

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

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

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

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

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

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

1 Act.

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

7 11. Persons with disabilities who are employed and
8 eligible for Medicaid, pursuant to Section
9 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,
10 subject to federal approval, persons with a medically
11 improved disability who are employed and eligible for
12 Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of
13 the Social Security Act, as provided by the Illinois
14 Department by rule. In establishing eligibility standards
15 under this paragraph 11, the Department shall, subject to
16 federal approval:

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

19 (b) exempt retirement accounts that the person
20 cannot access without penalty before the age of 59
21 1/2, and medical savings accounts established pursuant
22 to 26 U.S.C. 220;

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

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

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

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

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

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

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

1 3, 2001 (the effective date of Public Act 92-47) ~~this~~
2 ~~amendatory Act of the 92nd General Assembly.~~

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

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

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

24 15. Family Care Eligibility.

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

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

4 (b) Eligibility shall be reviewed annually.

5 (c) (Blank).

6 (d) (Blank).

7 (e) (Blank).

8 (f) (Blank).

9 (g) (Blank).

10 (h) (Blank).

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

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

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

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

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

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

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

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

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

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

7 19. Beginning January 1, 2014, as required under 42
8 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18
9 and younger than age 26 who are not otherwise eligible for
10 medical assistance under paragraphs (1) through (17) of
11 this Section who (i) were in foster care under the
12 responsibility of the State on the date of attaining age
13 18 or on the date of attaining age 21 when a court has
14 continued wardship for good cause as provided in Section
15 2-31 of the Juvenile Court Act of 1987 and (ii) received
16 medical assistance under the Illinois Title XIX State Plan
17 or waiver of such plan while in foster care.

18 20. Beginning January 1, 2018, persons who are
19 foreign-born victims of human trafficking, torture, or
20 other serious crimes as defined in Section 2-19 of this
21 Code and their derivative family members if such persons:
22 (i) reside in Illinois; (ii) are not eligible under any of
23 the preceding paragraphs; (iii) meet the income guidelines
24 of subparagraph (a) of paragraph 2; and (iv) meet the
25 nonfinancial eligibility requirements of Sections 16-2,
26 16-3, and 16-5 of this Code. The Department may extend

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

13 21. Persons who are not otherwise eligible for medical
14 assistance under this Section who may qualify for medical
15 assistance pursuant to 42 U.S.C.
16 1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the
17 duration of any federal or State declared emergency due to
18 COVID-19. Medical assistance to persons eligible for
19 medical assistance solely pursuant to this paragraph 21
20 shall be limited to any in vitro diagnostic product (and
21 the administration of such product) described in 42 U.S.C.
22 1396d(a)(3)(B) on or after March 18, 2020, any visit
23 described in 42 U.S.C. 1396o(a)(2)(G), or any other
24 medical assistance that may be federally authorized for
25 this class of persons. The Department may also cover
26 treatment of COVID-19 for this class of persons, or any

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

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

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

26 The Department shall by rule establish the amounts of

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

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

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

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

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

6 Notwithstanding any other provision of this Code, if an
7 Act of Congress that becomes a Public Law eliminates Section
8 2001(a) of Public Law 111-148, the State or a unit of local
9 government shall be prohibited from enrolling individuals in
10 the Medical Assistance Program as the result of federal
11 approval of a State Medicaid waiver on or after June 14, 2012
12 ~~(the effective date of Public Act 97-687) this amendatory Act~~
13 ~~of the 97th General Assembly~~, and any individuals enrolled in
14 the Medical Assistance Program pursuant to eligibility
15 permitted as a result of such a State Medicaid waiver shall
16 become immediately ineligible.

17 Effective October 1, 2013, the determination of
18 eligibility of persons who qualify under paragraphs 5, 6, 8,
19 15, 17, and 18 of this Section shall comply with the
20 requirements of 42 U.S.C. 1396a(e)(14) and applicable federal
21 regulations.

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

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

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

5 (305 ILCS 5/11-4.2 new)

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

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

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

1 submitting an application for enrollment in the medical
2 assistance program.

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

11 (305 ILCS 5/11-22d new)

12 Sec. 11-22d. Savings provisions.

13 (a) Notwithstanding any amendments or provisions in this
14 amendatory Act of the 102nd General Assembly which would make
15 the Children's Health Insurance Program Act or the Covering
16 ALL KIDS Health Insurance Act inoperative, Sections 11-22a,
17 11-22b, and 11-22c of this Code shall remain in force for the
18 commencement or continuation of any cause of action that (i)
19 accrued prior to the effective date of this amendatory Act of
20 the 102nd General Assembly or the date upon which the
21 Department receives federal approval of the changes made to
22 paragraph (6) of Section 5-2 by this amendatory Act of the
23 102nd General Assembly, whichever is later, and (ii) concerns
24 the recovery of any amount expended by the State for health
25 care benefits provided under the Children's Health Insurance

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

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

14 (305 ILCS 5/11-32 new)

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

1 (305 ILCS 5/12-4.35)

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

3 (a) Notwithstanding Section 1-11 of this Code or Section
4 20(a) of the Children's Health Insurance Program Act, the
5 Department of Healthcare and Family Services may provide
6 medical services to noncitizens who have not yet attained 19
7 years of age and who are not eligible for medical assistance
8 under Article V of this Code or under the Children's Health
9 Insurance Program created by the Children's Health Insurance
10 Program Act due to their not meeting the otherwise applicable
11 provisions of Section 1-11 of this Code or Section 20(a) of the
12 Children's Health Insurance Program Act. The medical services
13 available, standards for eligibility, and other conditions of
14 participation under this Section shall be established by rule
15 by the Department; however, any such rule shall be at least as
16 restrictive as the rules for medical assistance under Article
17 V of this Code or the Children's Health Insurance Program
18 created by the Children's Health Insurance Program Act.

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

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

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

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

20 (d) (Blank).

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

22 Article 30.

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

1 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

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

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

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

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

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

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

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

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

20 (2) eyeglasses prescribed by a physician skilled in
21 the diseases of the eye, or by an optometrist, whichever
22 the person may select.

23 On and after July 1, 2018, the Department of Healthcare
24 and Family Services shall provide dental services to any adult
25 who is otherwise eligible for assistance under the medical
26 assistance program. As used in this paragraph, "dental

1 services" means diagnostic, preventative, restorative, or
2 corrective procedures, including procedures and services for
3 the prevention and treatment of periodontal disease and dental
4 caries disease, provided by an individual who is licensed to
5 practice dentistry or dental surgery or who is under the
6 supervision of a dentist in the practice of his or her
7 profession.

8 On and after July 1, 2018, targeted dental services, as
9 set forth in Exhibit D of the Consent Decree entered by the
10 United States District Court for the Northern District of
11 Illinois, Eastern Division, in the matter of Memisovski v.
12 Maram, Case No. 92 C 1982, that are provided to adults under
13 the medical assistance program shall be established at no less
14 than the rates set forth in the "New Rate" column in Exhibit D
15 of the Consent Decree for targeted dental services that are
16 provided to persons under the age of 18 under the medical
17 assistance program.

18 Notwithstanding any other provision of this Code and
19 subject to federal approval, the Department may adopt rules to
20 allow a dentist who is volunteering his or her service at no
21 cost to render dental services through an enrolled
22 not-for-profit health clinic without the dentist personally
23 enrolling as a participating provider in the medical
24 assistance program. A not-for-profit health clinic shall
25 include a public health clinic or Federally Qualified Health
26 Center or other enrolled provider, as determined by the

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

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

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

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

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

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

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

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

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

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

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

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

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

1 tool.

2 For purposes of this Section:

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

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

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

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

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

1 Patient Protection and Affordable Care Act (Public Law
2 111-148), including, but not limited to, 42 U.S.C.
3 18031(d)(3)(B) or any successor provision, to defray the cost
4 of any coverage for breast tomosynthesis outlined in this
5 paragraph, then the requirement that an insurer cover breast
6 tomosynthesis is inoperative other than any such coverage
7 authorized under Section 1902 of the Social Security Act, 42
8 U.S.C. 1396a, and the State shall not assume any obligation
9 for the cost of coverage for breast tomosynthesis set forth in
10 this paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 The sponsor must negotiate formal written contracts with

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

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

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

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

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

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

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

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

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

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

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

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

17 Notwithstanding any other law to the contrary, the
18 Illinois Department shall, within 365 days after August 15,
19 2014 (the effective date of Public Act 98-963), establish
20 procedures to permit ID/DD facilities licensed under the ID/DD
21 Community Care Act and MC/DD facilities licensed under the
22 MC/DD Act to submit monthly billing claims for reimbursement
23 purposes. Following development of these procedures, the
24 Department shall have an additional 365 days to test the
25 viability of the new system and to ensure that any necessary
26 operational or structural changes to its information

1 technology platforms are implemented.

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

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

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

1 penalty.

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

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

17 The Department shall define or specify the following: (i)
18 by provider notice, the "category of risk of the vendor" for
19 each type of vendor, which shall take into account the level of
20 screening applicable to a particular category of vendor under
21 federal law and regulations; (ii) by rule or provider notice,
22 the maximum length of the conditional enrollment period for
23 each category of risk of the vendor; and (iii) by rule, the
24 hearing rights, if any, afforded to a vendor in each category
25 of risk of the vendor that is terminated or disenrolled during
26 the conditional enrollment period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 approval has been granted.

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

9 The Illinois Department shall report annually to the
10 General Assembly, no later than the second Friday in April of
11 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

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

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

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

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

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

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

1 the U.S. Food and Drug Administration.

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

14 A federally qualified health center, as defined in Section
15 1905(1)(2)(B) of the federal Social Security Act, shall be
16 reimbursed by the Department in accordance with the federally
17 qualified health center's encounter rate for services provided
18 to medical assistance recipients that are performed by a
19 dental hygienist, as defined under the Illinois Dental
20 Practice Act, working under the general supervision of a
21 dentist and employed by a federally qualified health center.

22 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
23 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
24 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
25 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
26 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.

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

2 (305 ILCS 5/5-5f)

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

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

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

1 services; (iii) the Department shall limit adult podiatry
2 services to individuals with diabetes; on or after October
3 1, 2014, podiatry services shall not be limited to
4 individuals with diabetes; (iv) the Department shall pay
5 for caesarean sections at the normal vaginal delivery rate
6 unless a caesarean section was medically necessary; (v)
7 the Department shall limit adult dental services to
8 emergencies; beginning July 1, 2013, the Department shall
9 ensure that the following conditions are recognized as
10 emergencies: (A) dental services necessary for an
11 individual in order for the individual to be cleared for a
12 medical procedure, such as a transplant; (B) extractions
13 and dentures necessary for a diabetic to receive proper
14 nutrition; (C) extractions and dentures necessary as a
15 result of cancer treatment; and (D) dental services
16 necessary for the health of a pregnant woman prior to
17 delivery of her baby; on or after July 1, 2014, adult
18 dental services shall no longer be limited to emergencies,
19 and dental services necessary for the health of a pregnant
20 woman prior to delivery of her baby shall continue to be
21 covered; and (vi) effective July 1, 2012, the Department
22 shall place limitations and require concurrent review on
23 every inpatient detoxification stay to prevent repeat
24 admissions to any hospital for detoxification within 60
25 days of a previous inpatient detoxification stay. The
26 Department shall convene a workgroup of hospitals,

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

7 (c) The Department shall require prior approval of the
8 following services: wheelchair repairs costing more than
9 \$400, coronary artery bypass graft, and bariatric surgery
10 consistent with Medicare standards concerning patient
11 responsibility. Wheelchair repair prior approval requests
12 shall be adjudicated within one business day of receipt of
13 complete supporting documentation. Providers may not break
14 wheelchair repairs into separate claims for purposes of
15 staying under the \$400 threshold for requiring prior
16 approval. The wholesale price of manual and power
17 wheelchairs, durable medical equipment and supplies, and
18 complex rehabilitation technology products and services
19 shall be defined as actual acquisition cost including all
20 discounts.

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

1 and historic and current trends in readmission. The
2 Department shall publish provider-specific historical
3 readmission data and anticipated potentially preventable
4 targets 60 days prior to the start of the program. In the
5 instance of readmissions, the Department shall adopt
6 policies and rates of reimbursement for services and other
7 payments provided under this Code to ensure that, by June
8 30, 2013, expenditures to hospitals are reduced by, at a
9 minimum, \$40,000,000.

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

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

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

1 cost-effective technology.

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

9 As used in this subsection (h):

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

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

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

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

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

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

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

12 Notwithstanding any other provision of this Section, all
13 tobacco cessation medications approved by the United States
14 Food and Drug Administration and all individual and group
15 tobacco cessation counseling services and telephone-based
16 counseling services and tobacco cessation medications provided
17 through the Illinois Tobacco Quitline shall be covered under
18 the medical assistance program for persons who are otherwise
19 eligible for assistance under this Article. The Department
20 shall comply with all federal requirements necessary to obtain
21 federal financial participation, as specified in 42 CFR
22 433.15(b)(7), for telephone-based counseling services provided
23 through the Illinois Tobacco Quitline, including, but not
24 limited to: (i) entering into a memorandum of understanding or
25 interagency agreement with the Department of Public Health, as
26 administrator of the Illinois Tobacco Quitline; and (ii)

1 developing a cost allocation plan for Medicaid-allowable
2 Illinois Tobacco Quitline services in accordance with 45 CFR
3 95.507. The Department shall submit the memorandum of
4 understanding or interagency agreement, the cost allocation
5 plan, and all other necessary documentation to the Centers for
6 Medicare and Medicaid Services for review and approval.
7 Coverage under this paragraph shall be contingent upon federal
8 approval.

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

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

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

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

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

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

21 (2) eyeglasses prescribed by a physician skilled in
22 the diseases of the eye, or by an optometrist, whichever
23 the person may select.

24 On and after July 1, 2018, the Department of Healthcare
25 and Family Services shall provide dental services to any adult
26 who is otherwise eligible for assistance under the medical

1 assistance program. As used in this paragraph, "dental
2 services" means diagnostic, preventative, restorative, or
3 corrective procedures, including procedures and services for
4 the prevention and treatment of periodontal disease and dental
5 caries disease, provided by an individual who is licensed to
6 practice dentistry or dental surgery or who is under the
7 supervision of a dentist in the practice of his or her
8 profession.

9 On and after July 1, 2018, targeted dental services, as
10 set forth in Exhibit D of the Consent Decree entered by the
11 United States District Court for the Northern District of
12 Illinois, Eastern Division, in the matter of Memisovski v.
13 Maram, Case No. 92 C 1982, that are provided to adults under
14 the medical assistance program shall be established at no less
15 than the rates set forth in the "New Rate" column in Exhibit D
16 of the Consent Decree for targeted dental services that are
17 provided to persons under the age of 18 under the medical
18 assistance program.

19 Notwithstanding any other provision of this Code and
20 subject to federal approval, the Department may adopt rules to
21 allow a dentist who is volunteering his or her service at no
22 cost to render dental services through an enrolled
23 not-for-profit health clinic without the dentist personally
24 enrolling as a participating provider in the medical
25 assistance program. A not-for-profit health clinic shall
26 include a public health clinic or Federally Qualified Health

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

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

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

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

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

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

26 (C) A mammogram at the age and intervals considered

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

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

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

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

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

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

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

3 For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 evaluation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 Notwithstanding any other law to the contrary, the
19 Illinois Department shall, within 365 days after August 15,
20 2014 (the effective date of Public Act 98-963), establish
21 procedures to permit ID/DD facilities licensed under the ID/DD
22 Community Care Act and MC/DD facilities licensed under the
23 MC/DD Act to submit monthly billing claims for reimbursement
24 purposes. Following development of these procedures, the
25 Department shall have an additional 365 days to test the
26 viability of the new system and to ensure that any necessary

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

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

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

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

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

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

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

18 The Department shall define or specify the following: (i)
19 by provider notice, the "category of risk of the vendor" for
20 each type of vendor, which shall take into account the level of
21 screening applicable to a particular category of vendor under
22 federal law and regulations; (ii) by rule or provider notice,
23 the maximum length of the conditional enrollment period for
24 each category of risk of the vendor; and (iii) by rule, the
25 hearing rights, if any, afforded to a vendor in each category
26 of risk of the vendor that is terminated or disenrolled during

1 the conditional enrollment period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 The Illinois Department shall report annually to the
11 General Assembly, no later than the second Friday in April of
12 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 A federally qualified health center, as defined in Section
16 1905(1)(2)(B) of the federal Social Security Act, shall be
17 reimbursed by the Department in accordance with the federally
18 qualified health center's encounter rate for services provided
19 to medical assistance recipients that are performed by a
20 dental hygienist, as defined under the Illinois Dental
21 Practice Act, working under the general supervision of a
22 dentist and employed by a federally qualified health center.

23 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
24 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
25 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
26 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;

1 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
2 1-1-20; revised 9-18-19.)

3 (305 ILCS 5/5-42 new)

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

15 Article 45.

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

18 (305 ILCS 5/12-4.35)

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

20 (a) Notwithstanding Section 1-11 of this Code or Section
21 20(a) of the Children's Health Insurance Program Act, the
22 Department of Healthcare and Family Services may provide

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

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

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

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

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

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

21 (d) (Blank).

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

23 Article 55.

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

1 changing Section 5-5 as follows:

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

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

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

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

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

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

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

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

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

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

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

18 (2) eyeglasses prescribed by a physician skilled in
19 the diseases of the eye, or by an optometrist, whichever
20 the person may select.

21 On and after July 1, 2018, the Department of Healthcare
22 and Family Services shall provide dental services to any adult
23 who is otherwise eligible for assistance under the medical
24 assistance program. As used in this paragraph, "dental
25 services" means diagnostic, preventative, restorative, or
26 corrective procedures, including procedures and services for

1 the prevention and treatment of periodontal disease and dental
2 caries disease, provided by an individual who is licensed to
3 practice dentistry or dental surgery or who is under the
4 supervision of a dentist in the practice of his or her
5 profession.

6 On and after July 1, 2018, targeted dental services, as
7 set forth in Exhibit D of the Consent Decree entered by the
8 United States District Court for the Northern District of
9 Illinois, Eastern Division, in the matter of Memisovski v.
10 Maram, Case No. 92 C 1982, that are provided to adults under
11 the medical assistance program shall be established at no less
12 than the rates set forth in the "New Rate" column in Exhibit D
13 of the Consent Decree for targeted dental services that are
14 provided to persons under the age of 18 under the medical
15 assistance program.

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

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

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

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

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

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

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

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

1 positive genetic testing, or other risk factors.

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

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

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

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

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

26 For purposes of this Section:

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

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

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

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

19 If, at any time, the Secretary of the United States
20 Department of Health and Human Services, or its successor
21 agency, promulgates rules or regulations to be published in
22 the Federal Register or publishes a comment in the Federal
23 Register or issues an opinion, guidance, or other action that
24 would require the State, pursuant to any provision of the
25 Patient Protection and Affordable Care Act (Public Law
26 111-148), including, but not limited to, 42 U.S.C.

1 18031(d)(3)(B) or any successor provision, to defray the cost
2 of any coverage for breast tomosynthesis outlined in this
3 paragraph, then the requirement that an insurer cover breast
4 tomosynthesis is inoperative other than any such coverage
5 authorized under Section 1902 of the Social Security Act, 42
6 U.S.C. 1396a, and the State shall not assume any obligation
7 for the cost of coverage for breast tomosynthesis set forth in
8 this paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 to recipients of medical assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 Notwithstanding any other law to the contrary, the
16 Illinois Department shall, within 365 days after August 15,
17 2014 (the effective date of Public Act 98-963), establish
18 procedures to permit ID/DD facilities licensed under the ID/DD
19 Community Care Act and MC/DD facilities licensed under the
20 MC/DD Act to submit monthly billing claims for reimbursement
21 purposes. Following development of these procedures, the
22 Department shall have an additional 365 days to test the
23 viability of the new system and to ensure that any necessary
24 operational or structural changes to its information
25 technology platforms are implemented.

26 The Illinois Department shall require all dispensers of

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

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

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

26 The Department has the discretion to limit the conditional

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

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

15 The Department shall define or specify the following: (i)
16 by provider notice, the "category of risk of the vendor" for
17 each type of vendor, which shall take into account the level of
18 screening applicable to a particular category of vendor under
19 federal law and regulations; (ii) by rule or provider notice,
20 the maximum length of the conditional enrollment period for
21 each category of risk of the vendor; and (iii) by rule, the
22 hearing rights, if any, afforded to a vendor in each category
23 of risk of the vendor that is terminated or disenrolled during
24 the conditional enrollment period.

25 To be eligible for payment consideration, a vendor's
26 payment claim or bill, either as an initial claim or as a

1 resubmitted claim following prior rejection, must be received
2 by the Illinois Department, or its fiscal intermediary, no
3 later than 180 days after the latest date on the claim on which
4 medical goods or services were provided, with the following
5 exceptions:

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

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

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

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

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

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

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

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

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

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

10 The Illinois Department shall enter into agreements with
11 State agencies and departments, and is authorized to enter
12 into agreements with federal agencies and departments, under
13 which such agencies and departments shall share data necessary
14 for medical assistance program integrity functions and
15 oversight. The Illinois Department shall develop, in
16 cooperation with other State departments and agencies, and in
17 compliance with applicable federal laws and regulations,
18 appropriate and effective methods to share such data. At a
19 minimum, and to the extent necessary to provide data sharing,
20 the Illinois Department shall enter into agreements with State
21 agencies and departments, and is authorized to enter into
22 agreements with federal agencies and departments, including,
23 but not limited to: the Secretary of State; the Department of
24 Revenue; the Department of Public Health; the Department of
25 Human Services; and the Department of Financial and
26 Professional Regulation.

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

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

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

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

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

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

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

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

26 The Illinois Department shall develop and operate, in

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

7 The Illinois Department shall report annually to the
8 General Assembly, no later than the second Friday in April of
9 1979 and each year thereafter, in regard to:

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

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

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

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

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

1 Library Act.

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

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

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

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

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

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

26 Upon federal approval, the Department shall provide

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

12 A federally qualified health center, as defined in Section
13 1905(1)(2)(B) of the federal Social Security Act, shall be
14 reimbursed by the Department in accordance with the federally
15 qualified health center's encounter rate for services provided
16 to medical assistance recipients that are performed by a
17 dental hygienist, as defined under the Illinois Dental
18 Practice Act, working under the general supervision of a
19 dentist and employed by a federally qualified health center.

20 Subject to approval by the federal Centers for Medicare
21 and Medicaid Services of a Title XIX State Plan amendment
22 electing the Program of All-Inclusive Care for the Elderly
23 (PACE) as a State Medicaid option, as provided for by Subtitle
24 I (commencing with Section 4801) of Title IV of the Balanced
25 Budget Act of 1997 (Public Law 105-33) and Part 460
26 (commencing with Section 460.2) of Subchapter E of Title 42 of

1 the Code of Federal Regulations, PACE program services shall
2 become a covered benefit of the medical assistance program,
3 subject to criteria established in accordance with all
4 applicable laws.

5 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
6 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
7 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
8 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
9 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
10 1-1-20; revised 9-18-19.)

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

14 (320 ILCS 40/1) (from Ch. 23, par. 6901)

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

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

18 (320 ILCS 40/6 new)

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

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

22 "PACE organization" means an entity as defined in 42 CFR
23 460.6.

1 (320 ILCS 40/15) (from Ch. 23, par. 6915)

2 Sec. 15. Program implementation.

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

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

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

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

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

16 (e) The requirements of the PACE model, as provided for
17 under Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934
18 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act,
19 shall not be waived or modified. The requirements that shall
20 not be waived or modified include all of the following:

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

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

26 (3) The interdisciplinary team approach to care

1 management and service delivery.

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

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

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

10 (A) All Medicare-covered items and services.

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

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

16 (f) The provisions under Sections 1-7 and 5-4 of the
17 Illinois Public Aid Code and under 80 Ill. Adm. Code 120.379,
18 120.380, and 120.385 shall apply when determining the
19 eligibility for medical assistance of a person receiving PACE
20 services from an organization providing services under this
21 Act.

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

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

8 (A) Composition of PACE interdisciplinary teams.

9 (B) Use of community-based physicians.

10 (C) Marketing practices.

11 (D) Development of a streamlined PACE waiver process.

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

14 (i) Each PACE organization shall provide the Department
15 with required reporting documents as set forth in 42 CFR
16 460.190 through 42 CFR 460.196.

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

18 (320 ILCS 40/16 new)

19 Sec. 16. Rates of payment.

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

25 The Department may develop capitation rates using a

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

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

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

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

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

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

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

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

10 (320 ILCS 40/20) (from Ch. 23, par. 6920)

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

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

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

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

1 (d) The Department of Healthcare and Family Services or
2 its designee shall be responsible for certifying the
3 eligibility for services of all PACE program participants.

4 (Source: P.A. 95-331, eff. 8-21-07.)

5 (320 ILCS 40/30 rep.)

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

8 Article 65.

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

11 (305 ILCS 5/5-19) (from Ch. 23, par. 5-19)

12 Sec. 5-19. Healthy Kids Program.

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

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

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

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

11 (d) Medical Screening Examinations.

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

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

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

1 or educational personnel; or

2 (B) necessary for enrollment in school; or

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

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

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

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

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

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

17 (I) deemed appropriate by the Illinois Department.

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

21 (1) Comprehensive Health and Development Assessment
22 including:

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

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

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

3 (2) Comprehensive unclothed physical exam;

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

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

9 (A) Anemia test.

10 (B) Sickle cell test.

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

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

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

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

26 (7) Hearing Screening. The Illinois Department shall

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

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

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

15 (g) Notice of Healthy Kids Services.

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

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

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

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

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

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

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

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

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

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

1 Section, on and after January 1, 2022, the Illinois Department
2 shall ensure that provider and hospital reimbursements for
3 immunization as required under this Section are no lower than
4 70% of the median regional maximum administration fee for the
5 State of Illinois as established by the U.S. Department of
6 Health and Human Services' Centers for Medicare and Medicaid
7 Services.

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

9 Article 70.

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

12 (305 ILCS 5/5-5.01a)

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

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

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

1 their own separate, private, and distinct living units.

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

6 (b) Beginning July 1, 2014, subject to federal approval,
7 the Medicaid rates for supportive living facilities shall be
8 equal to the supportive living facility Medicaid rate
9 effective on June 30, 2014 increased by 8.85%. Once the
10 assessment imposed at Article V-G of this Code is determined
11 to be a permissible tax under Title XIX of the Social Security
12 Act, the Department shall increase the Medicaid rates for
13 supportive living facilities effective on July 1, 2014 by
14 9.09%. The Department shall apply this increase retroactively
15 to coincide with the imposition of the assessment in Article
16 V-G of this Code in accordance with the approval for federal
17 financial participation by the Centers for Medicare and
18 Medicaid Services.

19 The Medicaid rates for supportive living facilities
20 effective on July 1, 2017 must be equal to the rates in effect
21 for supportive living facilities on June 30, 2017 increased by
22 2.8%.

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

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

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

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

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

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

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

1 used for the provision of supportive living program
2 services; and

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

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

11 (f) Section 9817 of the American Rescue Plan Act of 2021
12 (Public Law 117-2) authorizes a 10% enhanced federal medical
13 assistance percentage for supportive living services for a
14 12-month period from April 1, 2021 through March 31, 2022.
15 Subject to federal approval, including the approval of any
16 necessary waiver amendments or other federally required
17 documents or assurances, for a 12-month period the Department
18 must pay a supplemental \$26 per diem rate to all supportive
19 living facilities with the additional federal financial
20 participation funds that result from the enhanced federal
21 medical assistance percentage from April 1, 2021 through March
22 31, 2022. The Department may issue parameters around how the
23 supplemental payment should be spent, including quality
24 improvement activities. The Department may alter the form,
25 methods, or timeframes concerning the supplemental per diem
26 rate to comply with any subsequent changes to federal law,

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

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

6 Article 75.

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

9 (20 ILCS 3860/997 new)

10 Sec. 997. Repealer. This Act is repealed on January 1,
11 2027.

12 Article 80.

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

15 (305 ILCS 5/5-5f)

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

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

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

5 (b) The Department shall place the following
6 limitations on services: (i) the Department shall limit
7 adult eyeglasses to one pair every 2 years; however, the
8 limitation does not apply to an individual who needs
9 different eyeglasses following a surgical procedure such
10 as cataract surgery; (ii) the Department shall set an
11 annual limit of a maximum of 20 visits for each of the
12 following services: adult speech, hearing, and language
13 therapy services, adult occupational therapy services, and
14 physical therapy services; on or after October 1, 2014,
15 the annual maximum limit of 20 visits shall expire but the
16 Department may require prior approval for all individuals
17 for speech, hearing, and language therapy services,
18 occupational therapy services, and physical therapy
19 services; (iii) the Department shall limit adult podiatry
20 services to individuals with diabetes; on or after October
21 1, 2014, podiatry services shall not be limited to
22 individuals with diabetes; (iv) the Department shall pay
23 for caesarean sections at the normal vaginal delivery rate
24 unless a caesarean section was medically necessary; (v)
25 the Department shall limit adult dental services to
26 emergencies; beginning July 1, 2013, the Department shall

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

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

1 \$750 ~~\$400~~, coronary artery bypass graft, and bariatric
2 surgery consistent with Medicare standards concerning
3 patient responsibility. Wheelchair repair prior approval
4 requests shall be adjudicated within one business day of
5 receipt of complete supporting documentation. Providers
6 may not break wheelchair repairs into separate claims for
7 purposes of staying under the \$750 ~~\$400~~ threshold for
8 requiring prior approval. The wholesale price of manual
9 and power wheelchairs, durable medical equipment and
10 supplies, and complex rehabilitation technology products
11 and services shall be defined as actual acquisition cost
12 including all discounts.

13 (d) The Department shall establish benchmarks for
14 hospitals to measure and align payments to reduce
15 potentially preventable hospital readmissions, inpatient
16 complications, and unnecessary emergency room visits. In
17 doing so, the Department shall consider items, including,
18 but not limited to, historic and current acuity of care
19 and historic and current trends in readmission. The
20 Department shall publish provider-specific historical
21 readmission data and anticipated potentially preventable
22 targets 60 days prior to the start of the program. In the
23 instance of readmissions, the Department shall adopt
24 policies and rates of reimbursement for services and other
25 payments provided under this Code to ensure that, by June
26 30, 2013, expenditures to hospitals are reduced by, at a

1 minimum, \$40,000,000.

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

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

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

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

1 As used in this subsection (h):

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

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

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

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

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

21 Article 85.

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

1 (105 ILCS 5/14-15.01) (from Ch. 122, par. 14-15.01)
2 Sec. 14-15.01. Community and Residential Services
3 Authority.

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

6 A representative of the State Board of Education;

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

13 A representative of the Department of Children and Family
14 Services;

15 A representative of the Department of Juvenile Justice;

16 A representative of the Department of Healthcare and
17 Family Services;

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

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

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

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

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

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

19 (i) An appointee dies;

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

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

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

26 Members who are representatives of an agency shall serve

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

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

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

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

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

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

26 (4) To review the criteria for service eligibility,

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

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

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

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

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

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

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

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

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

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

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

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

1 adding Section 5-43 as follows:

2 (305 ILCS 5/5-43 new)

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

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

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

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

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

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

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

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

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

1 program.

2 (c) Subject to appropriation, no later than January 1,
3 2024, the Department of Healthcare and Family Services shall
4 apply to the federal Centers for Medicare and Medicaid
5 Services for a supports waiver for young adults with
6 developmental disabilities utilizing the information learned
7 from the study under subsection (a).

8 Article 95.

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

11 (305 ILCS 5/5-5.06a new)

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

17 Article 105.

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

20 (305 ILCS 5/5-30.1)

1 Sec. 5-30.1. Managed care protections.

2 (a) As used in this Section:

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

6 "Emergency services" include:

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

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

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

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

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

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

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

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

7 (1) the MCO authorized such services;

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

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

14 (4) the MCO could not be contacted; or

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

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

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

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

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

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

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

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

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

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

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

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

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

14 (D) the enrollee is discharged.

15 (f) Network adequacy and transparency.

16 (1) The Department shall:

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

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

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

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

1 and

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

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

19 (g) Timely payment of claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (A) the extension of the timely filing period;

19 (B) retroactive prior authorizations; and

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

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

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

5 (g-6) MCO Performance Metrics Report.

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

10 (A) claims payment, including timeliness and
11 accuracy;

12 (B) prior authorizations;

13 (C) grievance and appeals;

14 (D) utilization statistics;

15 (E) provider disputes;

16 (F) provider credentialing; and

17 (G) member and provider customer service.

18 (2) The Department shall ensure that the metrics
19 report is accessible to providers online by January 1,
20 2017.

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

26 (4) Metrics shall be defined and incorporated into the

1 applicable Managed Care Policy Manual issued by the
2 Department.

3 (g-7) MCO claims processing and performance analysis. In
4 order to monitor MCO payments to hospital providers, pursuant
5 to this amendatory Act of the 100th General Assembly, the
6 Department shall post an analysis of MCO claims processing and
7 payment performance on its website every 6 months. Such
8 analysis shall include a review and evaluation of a
9 representative sample of hospital claims that are rejected and
10 denied for clean and unclean claims and the top 5 reasons for
11 such actions and timeliness of claims adjudication, which
12 identifies the percentage of claims adjudicated within 30, 60,
13 90, and over 90 days, and the dollar amounts associated with
14 those claims. ~~The Department shall post the contracted claims~~
15 ~~report required by HealthChoice Illinois on its website every~~
16 ~~3 months.~~

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

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

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

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

15 (A) Premium revenue, with appropriate adjustments.

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

18 (i) Direct paid claims.

19 (ii) Subcapitation payments.

20 (iii) Other claim payments.

21 (iv) Direct reserves.

22 (v) Gross recoveries.

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

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

1 period determined by the Department.

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

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

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

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

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

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

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

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

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

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

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

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

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

19 (j) Health care information released to managed care
20 organizations. A health care provider shall release to a
21 Medicaid managed care organization, upon request, and subject
22 to the Health Insurance Portability and Accountability Act of
23 1996 and any other law applicable to the release of health
24 information, the health care information of the MCO's
25 enrollee, if the enrollee has completed and signed a general
26 release form that grants to the health care provider

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

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

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

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

14 Article 999.

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