



103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB2050

Introduced 2/7/2023, by Rep. Dagmara Avelar

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

from Ch. 23, par. 5-5

305 ILCS 5/5-5.06f new

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that on and after July 1, 2023, medically necessary orthodontic services may be covered under the medical assistance program. Requires the Department of Healthcare and Family Services to use certain auto-qualifiers when determining whether an individual, who is otherwise eligible for medical assistance, is also eligible for coverage for a medically necessary orthodontic service. Provides that if the Department denies a claim for a medically necessary orthodontic service, the Department must, at a minimum, provide the following information to the provider of the orthodontic service: (i) the actual score of the orthodontic case; (ii) the name of the dentist or orthodontist who scored the orthodontic case; (iii) a detailed scoring sheet outlining the reasons for the score of the orthodontic case; and (iv) instructions on how to appeal the denied claim.

LRB103 03523 KTG 48529 b

1 AN ACT concerning public aid.

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

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Section 5-5 and by adding Section 5-5.06f as follows:

6 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

7 (Text of Section after amendment by P.A. 102-1018 and P.A.
8 102-1038)

9 Sec. 5-5. Medical services. The Illinois Department, by
10 rule, shall determine the quantity and quality of and the rate
11 of reimbursement for the medical assistance for which payment
12 will be authorized, and the medical services to be provided,
13 which may include all or part of the following: (1) inpatient
14 hospital services; (2) outpatient hospital services; (3) other
15 laboratory and X-ray services; (4) skilled nursing home
16 services; (5) physicians' services whether furnished in the
17 office, the patient's home, a hospital, a skilled nursing
18 home, or elsewhere; (6) medical care, or any other type of
19 remedial care furnished by licensed practitioners; (7) home
20 health care services; (8) private duty nursing service; (9)
21 clinic services; (10) dental services, including prevention
22 and treatment of periodontal disease and dental caries disease
23 for pregnant individuals, provided by an individual licensed

1 to practice dentistry or dental surgery, and on and after July
2 1, 2023, medically necessary orthodontic services as provided
3 in Section 5-5.06f; for purposes of this item (10), "dental
4 services" means diagnostic, preventive, or corrective
5 procedures provided by or under the supervision of a dentist
6 in the practice of his or her profession; (11) physical
7 therapy and related services; (12) prescribed drugs, dentures,
8 and prosthetic devices; and eyeglasses prescribed by a
9 physician skilled in the diseases of the eye, or by an
10 optometrist, whichever the person may select; (13) other
11 diagnostic, screening, preventive, and rehabilitative
12 services, including to ensure that the individual's need for
13 intervention or treatment of mental disorders or substance use
14 disorders or co-occurring mental health and substance use
15 disorders is determined using a uniform screening, assessment,
16 and evaluation process inclusive of criteria, for children and
17 adults; for purposes of this item (13), a uniform screening,
18 assessment, and evaluation process refers to a process that
19 includes an appropriate evaluation and, as warranted, a
20 referral; "uniform" does not mean the use of a singular
21 instrument, tool, or process that all must utilize; (14)
22 transportation and such other expenses as may be necessary;
23 (15) medical treatment of sexual assault survivors, as defined
24 in Section 1a of the Sexual Assault Survivors Emergency
25 Treatment Act, for injuries sustained as a result of the
26 sexual assault, including examinations and laboratory tests to

1 discover evidence which may be used in criminal proceedings
2 arising from the sexual assault; (16) the diagnosis and
3 treatment of sickle cell anemia; (16.5) services performed by
4 a chiropractic physician licensed under the Medical Practice
5 Act of 1987 and acting within the scope of his or her license,
6 including, but not limited to, chiropractic manipulative
7 treatment; and (17) any other medical care, and any other type
8 of remedial care recognized under the laws of this State. The
9 term "any other type of remedial care" shall include nursing
10 care and nursing home service for persons who rely on
11 treatment by spiritual means alone through prayer for healing.

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

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

24 Notwithstanding any other provision of this Section, all
25 tobacco cessation medications approved by the United States
26 Food and Drug Administration and all individual and group

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

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

1 documentation.

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

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

26 (1) dental services provided by or under the

1 supervision of a dentist; and

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

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

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

26 Notwithstanding any other provision of this Code and

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

13 On and after January 1, 2022, the Department of Healthcare
14 and Family Services shall administer and regulate a
15 school-based dental program that allows for the out-of-office
16 delivery of preventative dental services in a school setting
17 to children under 19 years of age. The Department shall
18 establish, by rule, guidelines for participation by providers
19 and set requirements for follow-up referral care based on the
20 requirements established in the Dental Office Reference Manual
21 published by the Department that establishes the requirements
22 for dentists participating in the All Kids Dental School
23 Program. Every effort shall be made by the Department when
24 developing the program requirements to consider the different
25 geographic differences of both urban and rural areas of the
26 State for initial treatment and necessary follow-up care. No

1 provider shall be charged a fee by any unit of local government
2 to participate in the school-based dental program administered
3 by the Department. Nothing in this paragraph shall be
4 construed to limit or preempt a home rule unit's or school
5 district's authority to establish, change, or administer a
6 school-based dental program in addition to, or independent of,
7 the school-based dental program administered by the
8 Department.

9 The Illinois Department, by rule, may distinguish and
10 classify the medical services to be provided only in
11 accordance with the classes of persons designated in Section
12 5-2.

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

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

25 (A) A baseline mammogram for individuals 35 to 39
26 years of age.

1 (B) An annual mammogram for individuals 40 years of
2 age or older.

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

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

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

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

21 The Department shall not impose a deductible, coinsurance,
22 copayment, or any other cost-sharing requirement on the
23 coverage provided under this paragraph; except that this
24 sentence does not apply to coverage of diagnostic mammograms
25 to the extent such coverage would disqualify a high-deductible
26 health plan from eligibility for a health savings account

1 pursuant to Section 223 of the Internal Revenue Code (26
2 U.S.C. 223).

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

7 For purposes of this Section:

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

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

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

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

26 If, at any time, the Secretary of the United States

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

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

21 On and after January 1, 2012, providers participating in a
22 quality improvement program approved by the Department shall
23 be reimbursed for screening and diagnostic mammography at the
24 same rate as the Medicare program's rates, including the
25 increased reimbursement for digital mammography and, after
26 January 1, 2023 (the effective date of Public Act 102-1018)

1 ~~this amendatory Act of the 102nd General Assembly~~, breast
2 tomosynthesis.

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

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

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

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

26 The Department shall establish a methodology to remind

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

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

15 The Department shall devise a means of case-managing or
16 patient navigation for beneficiaries diagnosed with breast
17 cancer. This program shall initially operate as a pilot
18 program in areas of the State with the highest incidence of
19 mortality related to breast cancer. At least one pilot program
20 site shall be in the metropolitan Chicago area and at least one
21 site shall be outside the metropolitan Chicago area. On or
22 after July 1, 2016, the pilot program shall be expanded to
23 include one site in western Illinois, one site in southern
24 Illinois, one site in central Illinois, and 4 sites within
25 metropolitan Chicago. An evaluation of the pilot program shall
26 be carried out measuring health outcomes and cost of care for

1 those served by the pilot program compared to similarly
2 situated patients who are not served by the pilot program.

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

11 The Department shall provide coverage and reimbursement
12 for a human papillomavirus (HPV) vaccine that is approved for
13 marketing by the federal Food and Drug Administration for all
14 persons between the ages of 9 and 45 and persons of the age of
15 46 and above who have been diagnosed with cervical dysplasia
16 with a high risk of recurrence or progression. The Department
17 shall disallow any preauthorization requirements for the
18 administration of the human papillomavirus (HPV) vaccine.

19 On or after July 1, 2022, individuals who are otherwise
20 eligible for medical assistance under this Article shall
21 receive coverage for perinatal depression screenings for the
22 12-month period beginning on the last day of their pregnancy.
23 Medical assistance coverage under this paragraph shall be
24 conditioned on the use of a screening instrument approved by
25 the Department.

26 Any medical or health care provider shall immediately

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

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

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

1 Neither the Department of Healthcare and Family Services
2 nor the Department of Human Services shall sanction the
3 recipient solely on the basis of the recipient's substance
4 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 120
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 the 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 or hospital fees related to the dispensing, distribution,
18 and administration of the opioid antagonist, shall be covered
19 under the medical assistance program for persons who are
20 otherwise eligible for medical assistance under this Article.
21 As used in this Section, "opioid antagonist" means a drug that
22 binds to opioid receptors and blocks or inhibits the effect of
23 opioids acting on those receptors, including, but not limited
24 to, naloxone hydrochloride or any other similarly acting drug
25 approved by the U.S. Food and Drug Administration. The
26 Department shall not impose a copayment on the coverage

1 provided for naloxone hydrochloride under the medical
2 assistance program.

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 Within 90 days after October 8, 2021 (the effective date
24 of Public Act 102-665), the Department shall seek federal
25 approval of a State Plan amendment to expand coverage for
26 family planning services that includes presumptive eligibility

1 to individuals whose income is at or below 208% of the federal
2 poverty level. Coverage under this Section shall be effective
3 beginning no later than December 1, 2022.

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

15 Notwithstanding any other provision of this Code,
16 community-based pediatric palliative care from a trained
17 interdisciplinary team shall be covered under the medical
18 assistance program as provided in Section 15 of the Pediatric
19 Palliative Care Act.

20 Notwithstanding any other provision of this Code, within
21 12 months after June 2, 2022 (the effective date of Public Act
22 102-1037) ~~this amendatory Act of the 102nd General Assembly~~
23 and subject to federal approval, acupuncture services
24 performed by an acupuncturist licensed under the Acupuncture
25 Practice Act who is acting within the scope of his or her
26 license shall be covered under the medical assistance program.

1 The Department shall apply for any federal waiver or State
2 Plan amendment, if required, to implement this paragraph. The
3 Department may adopt any rules, including standards and
4 criteria, necessary to implement this paragraph.

5 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;
6 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article
7 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section
8 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;
9 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.
10 1-1-22; 102-665, eff. 10-8-21; 102-813, eff. 5-13-22;
11 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22; 102-1038 eff.
12 1-1-23; revised 8-9-22.)

13 (305 ILCS 5/5-5.06f new)

14 Sec. 5-5.06f. Medically necessary orthodontic services;
15 criteria for coverage.

16 (a) As used in this Section, "medically necessary
17 orthodontic services" means orthodontic services to prevent,
18 diagnose, minimize, alleviate, correct, or resolve a
19 malocclusion (including craniofacial abnormalities and
20 traumatic or pathologic anatomical deviations) that causes
21 pain or suffering, physical deformity, or significant
22 malfunction, that aggravates another condition, or that
23 results in further injury or infirmity.

24 (b) On and after July 1, 2023, the Department shall use the
25 following auto-qualifiers when determining whether an

1 individual, who is otherwise eligible for medical assistance,
2 is also eligible for coverage for a medically necessary
3 orthodontic service:

4 (1) Overjet: 9 mm or more.

5 (2) Reverse overjet: 3.5 mm or more.

6 (3) Anterior or posterior crossbite of 3 or more teeth
7 per arch.

8 (4) Lateral or anterior open bite: 2 mm or more, of 4
9 or more teeth per arch.

10 (5) Impinging overbite with evidence of occlusal
11 contact into the opposing soft tissue.

12 (6) Impactions where eruption is impeded, but
13 extraction is not indicated (excluding third molars).

14 (7) Jaws or dentition which are profoundly affected by
15 a congenital or developmental disorder (craniofacial
16 anomalies), trauma, or pathology.

17 (8) Congenitally missing teeth (excluding third
18 molars) of at least one tooth per quadrant.

19 (9) Crowding or spacing of 10 mm or more, in either the
20 maxillary or mandibular arch (excluding third molars).

21 (c) If the Department denies a claim for a medically
22 necessary orthodontic service, the Department must, at a
23 minimum, provide the following information to the provider of
24 the orthodontic service:

25 (1) The actual score of the orthodontic case.

26 (2) The name of the dentist or orthodontist who scored

1 the orthodontic case.

2 (3) A detailed scoring sheet outlining the reasons for
3 the score of the orthodontic case.

4 (4) Instructions on how to appeal the denied claim.