

1 AN ACT concerning regulation.

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

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

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

7 (Text of Section before amendment by P.A. 99-407)

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

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

1 care, and any other type of remedial care recognized under the
2 laws of this State, but not including abortions, or induced
3 miscarriages or premature births, unless, in the opinion of a
4 physician, such procedures are necessary for the preservation
5 of the life of the woman seeking such treatment, or except an
6 induced premature birth intended to produce a live viable child
7 and such procedure is necessary for the health of the mother or
8 her unborn child. The Illinois Department, by rule, shall
9 prohibit any physician from providing medical assistance to
10 anyone eligible therefor under this Code where such physician
11 has been found guilty of performing an abortion procedure in a
12 wilful and wanton manner upon a woman who was not pregnant at
13 the time such abortion procedure was performed. The term "any
14 other type of remedial care" shall include nursing care and
15 nursing home service for persons who rely on treatment by
16 spiritual means alone through prayer for healing.

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

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

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

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

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

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

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

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

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

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

24 The Department of Healthcare and Family Services must
25 provide coverage and reimbursement for amino acid-based
26 elemental formulas, regardless of delivery method, for the

1 diagnosis and treatment of (i) eosinophilic disorders and (ii)
2 short bowel syndrome when the prescribing physician has issued
3 a written order stating that the amino acid-based elemental
4 formula is medically necessary.

5 The Illinois Department shall authorize the provision of,
6 and shall authorize payment for, screening by low-dose
7 mammography for the presence of occult breast cancer for women
8 35 years of age or older who are eligible for medical
9 assistance under this Article, as follows:

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

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

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

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

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

1 All screenings shall include a physical breast exam,
2 instruction on self-examination and information regarding the
3 frequency of self-examination and its value as a preventative
4 tool. For purposes of this Section, "low-dose mammography"
5 means the x-ray examination of the breast using equipment
6 dedicated specifically for mammography, including the x-ray
7 tube, filter, compression device, and image receptor, with an
8 average radiation exposure delivery of less than one rad per
9 breast for 2 views of an average size breast. The term also
10 includes digital mammography.

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 Imaging
14 Excellence as certified by the American College of Radiology.

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

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

24 On and after January 1, 2017, providers participating in a
25 breast cancer treatment quality improvement program approved
26 by the Department shall be reimbursed for breast cancer

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

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

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

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

26 The Department shall establish a performance goal for

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

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

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

1 in-network covered benefit.

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

14 All medical providers providing medical assistance to
15 pregnant women under this Code shall receive information from
16 the Department on the availability of services under the Drug
17 Free Families with a Future or any comparable program providing
18 case management services for addicted women, including
19 information on appropriate referrals for other social services
20 that may be needed by addicted women in addition to treatment
21 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 a
25 public awareness campaign, may provide information concerning
26 treatment for alcoholism and drug abuse and addiction, prenatal

1 health care, and other pertinent programs directed at reducing
2 the number of drug-affected infants born to recipients of
3 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 projects
20 in certain geographic areas. The Partnership shall be
21 represented by a sponsor organization. The Department, by rule,
22 shall develop qualifications for sponsors of Partnerships.
23 Nothing in this Section shall be construed to require that the
24 sponsor organization be a medical organization.

25 The sponsor must negotiate formal written contracts with
26 medical providers for physician services, inpatient and

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

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

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

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

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

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

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

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

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

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

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

4 The rules and regulations of the Illinois Department shall
5 require that a written statement including the required opinion
6 of a physician shall accompany any claim for reimbursement for
7 abortions, or induced miscarriages or premature births. This
8 statement shall indicate what procedures were used in providing
9 such medical services.

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

21 Notwithstanding any other law to the contrary, the Illinois
22 Department shall, within 365 days after August 15, 2014 (the
23 effective date of Public Act 98-963), establish procedures to
24 permit ID/DD facilities licensed under the ID/DD Community Care
25 Act and MC/DD facilities licensed under the MC/DD Act to submit
26 monthly billing claims for reimbursement purposes. Following

1 development of these procedures, the Department shall have an
2 additional 365 days to test the viability of the new system and
3 to ensure that any necessary operational or structural changes
4 to its information technology platforms are implemented.

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

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

22 Enrollment of a vendor shall be subject to a provisional
23 period and shall be conditional for one year. During the period
24 of conditional enrollment, the Department may terminate the
25 vendor's eligibility to participate in, or may disenroll the
26 vendor from, the medical assistance program without cause.

1 Unless otherwise specified, such termination of eligibility or
2 disenrollment is not subject to the Department's hearing
3 process. However, a disenrolled vendor may reapply without
4 penalty.

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

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

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

1 hearing rights, if any, afforded to a vendor in each category
2 of risk of the vendor that is terminated or disenrolled during
3 the conditional enrollment period.

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

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

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

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

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

1 For claims for services rendered during a period for which
2 a recipient received retroactive eligibility, claims must be
3 filed within 180 days after the Department determines the
4 applicant is eligible. For claims for which the Illinois
5 Department is not the primary payer, claims must be submitted
6 to the Illinois Department within 180 days after the final
7 adjudication by the primary payer.

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

25 Claims that are not submitted and received in compliance
26 with the foregoing requirements shall not be eligible for

1 payment under the medical assistance program, and the State
2 shall have no liability for payment of those claims.

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

17 The Illinois Department shall enter into agreements with
18 State agencies and departments, and is authorized to enter into
19 agreements with federal agencies and departments, under which
20 such agencies and departments shall share data necessary for
21 medical assistance program integrity functions and oversight.
22 The Illinois Department shall develop, in cooperation with
23 other State departments and agencies, and in compliance with
24 applicable federal laws and regulations, appropriate and
25 effective methods to share such data. At a minimum, and to the
26 extent necessary to provide data sharing, the Illinois

1 Department shall enter into agreements with State agencies and
2 departments, and is authorized to enter into agreements with
3 federal agencies and departments, including but not limited to:
4 the Secretary of State; the Department of Revenue; the
5 Department of Public Health; the Department of Human Services;
6 and the Department of Financial and Professional Regulation.

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

21 The Illinois Department shall establish policies,
22 procedures, standards and criteria by rule for the acquisition,
23 repair and replacement of orthotic and prosthetic devices and
24 durable medical equipment. Such rules shall provide, but not be
25 limited to, the following services: (1) immediate repair or
26 replacement of such devices by recipients; and (2) rental,

1 lease, purchase or lease-purchase of durable medical equipment
2 in a cost-effective manner, taking into consideration the
3 recipient's medical prognosis, the extent of the recipient's
4 needs, and the requirements and costs for maintaining such
5 equipment. Subject to prior approval, such rules shall enable a
6 recipient to temporarily acquire and use alternative or
7 substitute devices or equipment pending repairs or
8 replacements of any device or equipment previously authorized
9 for such recipient by the Department.

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

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

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

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

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

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

1 the various medical services by medical vendors;

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

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

6 The period covered by each report shall be the 3 years
7 ending on the June 30 prior to the report. The report shall
8 include suggested legislation for consideration by the General
9 Assembly. The filing of one copy of the report with the
10 Speaker, one copy with the Minority Leader and one copy with
11 the Clerk of the House of Representatives, one copy with the
12 President, one copy with the Minority Leader and one copy with
13 the Secretary of the Senate, one copy with the Legislative
14 Research Unit, and such additional copies with the State
15 Government Report Distribution Center for the General Assembly
16 as is required under paragraph (t) of Section 7 of the State
17 Library Act shall be deemed sufficient to comply with this
18 Section.

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

25 On and after July 1, 2012, the Department shall reduce any
26 rate of reimbursement for services or other payments or alter

1 any methodologies authorized by this Code to reduce any rate of
2 reimbursement for services or other payments in accordance with
3 Section 5-5e.

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

20 Notwithstanding any other provision of this Code to the
21 contrary, on or after July 1, 2015, all FDA approved forms of
22 medication assisted treatment prescribed for the treatment of
23 alcohol dependence or treatment of opioid dependence shall be
24 covered under both fee for service and managed care medical
25 assistance programs for persons who are otherwise eligible for
26 medical assistance under this Article and shall not be subject

1 to any (1) utilization control, other than those established
2 under the American Society of Addiction Medicine patient
3 placement criteria, (2) prior authorization mandate, or (3)
4 lifetime restriction limit mandate.

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

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

1 individuals who are not infected with HIV but who are at high
2 risk of HIV infection.

3 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
4 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
5 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
6 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
7 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-433, eff.
8 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

9 (Text of Section after amendment by P.A. 99-407)

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

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

1 care, and any other type of remedial care recognized under the
2 laws of this State, but not including abortions, or induced
3 miscarriages or premature births, unless, in the opinion of a
4 physician, such procedures are necessary for the preservation
5 of the life of the woman seeking such treatment, or except an
6 induced premature birth intended to produce a live viable child
7 and such procedure is necessary for the health of the mother or
8 her unborn child. The Illinois Department, by rule, shall
9 prohibit any physician from providing medical assistance to
10 anyone eligible therefor under this Code where such physician
11 has been found guilty of performing an abortion procedure in a
12 wilful and wanton manner upon a woman who was not pregnant at
13 the time such abortion procedure was performed. The term "any
14 other type of remedial care" shall include nursing care and
15 nursing home service for persons who rely on treatment by
16 spiritual means alone through prayer for healing.

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

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

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

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

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

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

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

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

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

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

24 The Department of Healthcare and Family Services must
25 provide coverage and reimbursement for amino acid-based
26 elemental formulas, regardless of delivery method, for the

1 diagnosis and treatment of (i) eosinophilic disorders and (ii)
2 short bowel syndrome when the prescribing physician has issued
3 a written order stating that the amino acid-based elemental
4 formula is medically necessary.

5 The Illinois Department shall authorize the provision of,
6 and shall authorize payment for, screening by low-dose
7 mammography for the presence of occult breast cancer for women
8 35 years of age or older who are eligible for medical
9 assistance under this Article, as follows:

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

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

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

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

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

1 All screenings shall include a physical breast exam,
2 instruction on self-examination and information regarding the
3 frequency of self-examination and its value as a preventative
4 tool. For purposes of this Section, "low-dose mammography"
5 means the x-ray examination of the breast using equipment
6 dedicated specifically for mammography, including the x-ray
7 tube, filter, compression device, and image receptor, with an
8 average radiation exposure delivery of less than one rad per
9 breast for 2 views of an average size breast. The term also
10 includes digital mammography and includes breast
11 tomosynthesis. As used in this Section, the term "breast
12 tomosynthesis" means a radiologic procedure that involves the
13 acquisition of projection images over the stationary breast to
14 produce cross-sectional digital three-dimensional images of
15 the breast.

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 Imaging
19 Excellence as certified by the American College of Radiology.

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

25 The Department shall convene an expert panel including
26 representatives of hospitals, free-standing mammography

1 facilities, and doctors, including radiologists, to establish
2 quality standards for mammography.

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

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

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

22 The Department shall establish a methodology to remind
23 women who are age-appropriate for screening mammography, but
24 who have not received a mammogram within the previous 18
25 months, of the importance and benefit of screening mammography.
26 The Department shall work with experts in breast cancer

1 outreach and patient navigation to optimize these reminders and
2 shall establish a methodology for evaluating their
3 effectiveness and modifying the methodology based on the
4 evaluation.

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

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

25 The Department shall require all networks of care to
26 develop a means either internally or by contract with experts

1 in navigation and community outreach to navigate cancer
2 patients to comprehensive care in a timely fashion. The
3 Department shall require all networks of care to include access
4 for patients diagnosed with cancer to at least one academic
5 commission on cancer-accredited cancer program as an
6 in-network covered benefit.

7 Any medical or health care provider shall immediately
8 recommend, to any pregnant woman who is being provided prenatal
9 services and is suspected of drug abuse or is addicted as
10 defined in the Alcoholism and Other Drug Abuse and Dependency
11 Act, referral to a local substance abuse treatment provider
12 licensed by the Department of Human Services or to a licensed
13 hospital which provides substance abuse treatment services.
14 The Department of Healthcare and Family Services shall assure
15 coverage for the cost of treatment of the drug abuse or
16 addiction for pregnant recipients in accordance with the
17 Illinois Medicaid Program in conjunction with the Department of
18 Human Services.

19 All medical providers providing medical assistance to
20 pregnant women under this Code shall receive information from
21 the Department on the availability of services under the Drug
22 Free Families with a Future or any comparable program providing
23 case management services for addicted women, including
24 information on appropriate referrals for other social services
25 that may be needed by addicted women in addition to treatment
26 for addiction.

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

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

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

21 The Illinois Department may develop and contract with
22 Partnerships of medical providers to arrange medical services
23 for persons eligible under Section 5-2 of this Code.
24 Implementation of this Section may be by demonstration projects
25 in certain geographic areas. The Partnership shall be
26 represented by a sponsor organization. The Department, by rule,

1 shall develop qualifications for sponsors of Partnerships.
2 Nothing in this Section shall be construed to require that the
3 sponsor organization be a medical organization.

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

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

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

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

26 Medical providers shall be required to meet certain

1 qualifications to participate in Partnerships to ensure the
2 delivery of high quality medical services. These
3 qualifications shall be determined by rule of the Illinois
4 Department and may be higher than qualifications for
5 participation in the medical assistance program. Partnership
6 sponsors may prescribe reasonable additional qualifications
7 for participation by medical providers, only with the prior
8 written approval of the Illinois Department.

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

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

21 The Illinois Department shall require health care
22 providers to maintain records that document the medical care
23 and services provided to recipients of Medical Assistance under
24 this Article. Such records must be retained for a period of not
25 less than 6 years from the date of service or as provided by
26 applicable State law, whichever period is longer, except that

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

1 effective date of Public Act 83-1439) ~~this amendatory Act of~~
2 ~~1984~~, the Illinois Department shall establish a current list of
3 acquisition costs for all prosthetic devices and any other
4 items recognized as medical equipment and supplies
5 reimbursable under this Article and shall update such list on a
6 quarterly basis, except that the acquisition costs of all
7 prescription drugs shall be updated no less frequently than
8 every 30 days as required by Section 5-5.12.

9 The rules and regulations of the Illinois Department shall
10 require that a written statement including the required opinion
11 of a physician shall accompany any claim for reimbursement for
12 abortions, or induced miscarriages or premature births. This
13 statement shall indicate what procedures were used in providing
14 such medical services.

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

26 Notwithstanding any other law to the contrary, the Illinois

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

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

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

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

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

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

25 The Department shall define or specify the following: (i)
26 by provider notice, the "category of risk of the vendor" for

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

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

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

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

26 (3) In the case of a provider for whom the Illinois

1 Department initiates the monthly billing process.

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

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

13 In the case of long term care facilities, within 5 days of
14 receipt by the facility of required prescreening information,
15 data for new admissions shall be entered into the Medical
16 Electronic Data Interchange (MEDI) or the Recipient
17 Eligibility Verification (REV) System or successor system, and
18 within 15 days of receipt by the facility of required
19 prescreening information, admission documents shall be
20 submitted through MEDI or REV or shall be submitted directly to
21 the Department of Human Services using required admission
22 forms. Effective September 1, 2014, admission documents,
23 including all prescreening information, must be submitted
24 through MEDI or REV. Confirmation numbers assigned to an
25 accepted transaction shall be retained by a facility to verify
26 timely submittal. Once an admission transaction has been

1 completed, all resubmitted claims following prior rejection
2 are subject to receipt no later than 180 days after the
3 admission transaction has been completed.

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

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

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

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

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

26 The Illinois Department shall establish policies,

1 procedures, standards and criteria by rule for the acquisition,
2 repair and replacement of orthotic and prosthetic devices and
3 durable medical equipment. Such rules shall provide, but not be
4 limited to, the following services: (1) immediate repair or
5 replacement of such devices by recipients; and (2) rental,
6 lease, purchase or lease-purchase of durable medical equipment
7 in a cost-effective manner, taking into consideration the
8 recipient's medical prognosis, the extent of the recipient's
9 needs, and the requirements and costs for maintaining such
10 equipment. Subject to prior approval, such rules shall enable a
11 recipient to temporarily acquire and use alternative or
12 substitute devices or equipment pending repairs or
13 replacements of any device or equipment previously authorized
14 for such recipient by the Department.

15 The Department shall execute, relative to the nursing home
16 prescreening project, written inter-agency agreements with the
17 Department of Human Services and the Department on Aging, to
18 effect the following: (i) intake procedures and common
19 eligibility criteria for those persons who are receiving
20 non-institutional services; and (ii) the establishment and
21 development of non-institutional services in areas of the State
22 where they are not currently available or are undeveloped; and
23 (iii) notwithstanding any other provision of law, subject to
24 federal approval, on and after July 1, 2012, an increase in the
25 determination of need (DON) scores from 29 to 37 for applicants
26 for institutional and home and community-based long term care;

1 if and only if federal approval is not granted, the Department
2 may, in conjunction with other affected agencies, implement
3 utilization controls or changes in benefit packages to
4 effectuate a similar savings amount for this population; and
5 (iv) no later than July 1, 2013, minimum level of care
6 eligibility criteria for institutional and home and
7 community-based long term care; and (v) no later than October
8 1, 2013, establish procedures to permit long term care
9 providers access to eligibility scores for individuals with an
10 admission date who are seeking or receiving services from the
11 long term care provider. In order to select the minimum level
12 of care eligibility criteria, the Governor shall establish a
13 workgroup that includes affected agency representatives and
14 stakeholders representing the institutional and home and
15 community-based long term care interests. This Section shall
16 not restrict the Department from implementing lower level of
17 care eligibility criteria for community-based services in
18 circumstances where federal approval has been granted.

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

26 The Illinois Department shall report annually to the

1 General Assembly, no later than the second Friday in April of
2 1979 and each year thereafter, in regard to:

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

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

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

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

11 The period covered by each report shall be the 3 years
12 ending on the June 30 prior to the report. The report shall
13 include suggested legislation for consideration by the General
14 Assembly. The filing of one copy of the report with the
15 Speaker, one copy with the Minority Leader and one copy with
16 the Clerk of the House of Representatives, one copy with the
17 President, one copy with the Minority Leader and one copy with
18 the Secretary of the Senate, one copy with the Legislative
19 Research Unit, and such additional copies with the State
20 Government Report Distribution Center for the General Assembly
21 as is required under paragraph (t) of Section 7 of the State
22 Library Act shall be deemed sufficient to comply with this
23 Section.

24 Rulemaking authority to implement Public Act 95-1045, if
25 any, is conditioned on the rules being adopted in accordance
26 with all provisions of the Illinois Administrative Procedure

1 Act and all rules and procedures of the Joint Committee on
2 Administrative Rules; any purported rule not so adopted, for
3 whatever reason, is unauthorized.

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

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

25 Notwithstanding any other provision of this Code to the
26 contrary, on or after July 1, 2015, all FDA approved forms of

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

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

22 Upon federal approval, the Department shall provide
23 coverage and reimbursement for all drugs that are approved for
24 marketing by the federal Food and Drug Administration and that
25 are recommended by the federal Public Health Service or the
26 United States Centers for Disease Control and Prevention for

1 pre-exposure prophylaxis and related pre-exposure prophylaxis
2 services, including, but not limited to, HIV and sexually
3 transmitted infection screening, treatment for sexually
4 transmitted infections, medical monitoring, assorted labs, and
5 counseling to reduce the likelihood of HIV infection among
6 individuals who are not infected with HIV but who are at high
7 risk of HIV infection.

8 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
9 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
10 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
11 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
12 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
13 99 of P.A. 99-407 for its effective date); 99-433, eff.
14 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

15 Section 95. No acceleration or delay. Where this Act makes
16 changes in a statute that is represented in this Act by text
17 that is not yet or no longer in effect (for example, a Section
18 represented by multiple versions), the use of that text does
19 not accelerate or delay the taking effect of (i) the changes
20 made by this Act or (ii) provisions derived from any other
21 Public Act.

22 Section 99. Effective date. This Act takes effect January
23 1, 2017.