



99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB4957

Introduced 2/5/2016, by Rep. Michael W. Tryon

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

from Ch. 23, par. 5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to provide medical assistance coverage for diabetes education provided by a certified diabetes education provider for children with Type 1 diabetes who are under the age of 18. Defines "certified diabetes education provider" to mean a professional who has undergone training and certification under conditions approved by the American Association of Diabetes Educators or a successor association of professionals. Defines "Type 1 diabetes" to have the same meaning ascribed to it by the American Diabetes Association or any successor association. Effective immediately.

LRB099 19743 KTG 44141 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

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 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 Notwithstanding any other provision of this Code, the
6 Department shall provide medical assistance coverage for
7 diabetes education provided by a certified diabetes education
8 provider for children with Type 1 diabetes who are under the
9 age of 18. For purposes of this paragraph:

10 "Certified diabetes education provider" means a
11 professional who has undergone training and certification
12 under conditions approved by the American Association of
13 Diabetes Educators or a successor association of
14 professionals.

15 "Type 1 diabetes" shall have the same meaning ascribed
16 to it by the American Diabetes Association or any successor
17 association.

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

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

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

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

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

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

1 program. A not-for-profit health clinic shall include a public
2 health clinic or Federally Qualified Health Center or other
3 enrolled provider, as determined by the Department, through
4 which dental services covered under this Section are performed.
5 The Department shall establish a process for payment of claims
6 for reimbursement for covered dental services rendered under
7 this provision.

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

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

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

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

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

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

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

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

14 All screenings shall include a physical breast exam,
15 instruction on self-examination and information regarding the
16 frequency of self-examination and its value as a preventative
17 tool. For purposes of this Section, "low-dose mammography"
18 means the x-ray examination of the breast using equipment
19 dedicated specifically for mammography, including the x-ray
20 tube, filter, compression device, and image receptor, with an
21 average radiation exposure delivery of less than one rad per
22 breast for 2 views of an average size breast. The term also
23 includes digital mammography.

24 On and after January 1, 2016, the Department shall ensure
25 that all networks of care for adult clients of the Department
26 include access to at least one breast imaging Center of Imaging

1 Excellence as certified by the American College of Radiology.

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

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

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

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

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

1 hospital-based mammography facilities. By January 1, 2016, the
2 Department shall report to the General Assembly on the status
3 of the provision set forth in this paragraph.

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

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

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

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

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

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

1 All medical providers providing medical assistance to
2 pregnant women under this Code shall receive information from
3 the Department on the availability of services under the Drug
4 Free Families with a Future or any comparable program providing
5 case management services for addicted women, including
6 information on appropriate referrals for other social services
7 that may be needed by addicted women in addition to treatment
8 for addiction.

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

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

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

1 medical and health care providers, and consistency in
2 procedures to the Illinois Department.

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

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

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

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

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

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

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

26 The Department shall apply for a waiver from the United

1 States Health Care Financing Administration to allow for the
2 implementation of Partnerships under this Section.

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

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

17 The rules and regulations of the Illinois Department shall
18 require that a written statement including the required opinion
19 of a physician shall accompany any claim for reimbursement for
20 abortions, or induced miscarriages or premature births. This
21 statement shall indicate what procedures were used in providing
22 such medical services.

23 Notwithstanding any other law to the contrary, the Illinois
24 Department shall, within 365 days after July 22, 2013 (the
25 effective date of Public Act 98-104), establish procedures to
26 permit skilled care facilities licensed under the Nursing Home

1 Care Act to submit monthly billing claims for reimbursement
2 purposes. Following development of these procedures, the
3 Department shall, by July 1, 2016, test the viability of the
4 new system and implement any necessary operational or
5 structural changes to its information technology platforms in
6 order to allow for the direct acceptance and payment of nursing
7 home claims.

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

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

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

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

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

21 Prior to enrollment and during the conditional enrollment
22 period in the medical assistance program, all vendors shall be
23 subject to enhanced oversight, screening, and review based on
24 the risk of fraud, waste, and abuse that is posed by the
25 category of risk of the vendor. The Illinois Department shall
26 establish the procedures for oversight, screening, and review,

1 which may include, but need not be limited to: criminal and
2 financial background checks; fingerprinting; license,
3 certification, and authorization verifications; unscheduled or
4 unannounced site visits; database checks; prepayment audit
5 reviews; audits; payment caps; payment suspensions; and other
6 screening as required by federal or State law.

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

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

24 (1) In the case of a provider whose enrollment is in
25 process by the Illinois Department, the 180-day period
26 shall not begin until the date on the written notice from

1 the Illinois Department that the provider enrollment is
2 complete.

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

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

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

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

21 In the case of long term care facilities, within 5 days of
22 receipt by the facility of required prescreening information,
23 data for new admissions shall be entered into the Medical
24 Electronic Data Interchange (MEDI) or the Recipient
25 Eligibility Verification (REV) System or successor system, and
26 within 15 days of receipt by the facility of required

1 prescreening information, admission documents shall be
2 submitted through MEDI or REV or shall be submitted directly to
3 the Department of Human Services using required admission
4 forms. Effective September 1, 2014, admission documents,
5 including all prescreening information, must be submitted
6 through MEDI or REV. Confirmation numbers assigned to an
7 accepted transaction shall be retained by a facility to verify
8 timely submittal. Once an admission transaction has been
9 completed, all resubmitted claims following prior rejection
10 are subject to receipt no later than 180 days after the
11 admission transaction has been completed.

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

16 To the extent consistent with applicable information and
17 privacy, security, and disclosure laws, State and federal
18 agencies and departments shall provide the Illinois Department
19 access to confidential and other information and data necessary
20 to perform eligibility and payment verifications and other
21 Illinois Department functions. This includes, but is not
22 limited to: information pertaining to licensure;
23 certification; earnings; immigration status; citizenship; wage
24 reporting; unearned and earned income; pension income;
25 employment; supplemental security income; social security
26 numbers; National Provider Identifier (NPI) numbers; the

1 National Practitioner Data Bank (NPDB); program and agency
2 exclusions; taxpayer identification numbers; tax delinquency;
3 corporate information; and death records.

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

20 Beginning in fiscal year 2013, the Illinois Department
21 shall set forth a request for information to identify the
22 benefits of a pre-payment, post-adjudication, and post-edit
23 claims system with the goals of streamlining claims processing
24 and provider reimbursement, reducing the number of pending or
25 rejected claims, and helping to ensure a more transparent
26 adjudication process through the utilization of: (i) provider

1 data verification and provider screening technology; and (ii)
2 clinical code editing; and (iii) pre-pay, pre- or
3 post-adjudicated predictive modeling with an integrated case
4 management system with link analysis. Such a request for
5 information shall not be considered as a request for proposal
6 or as an obligation on the part of the Illinois Department to
7 take any action or acquire any products or services.

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

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

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

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

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

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

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

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

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

19 The period covered by each report shall be the 3 years
20 ending on the June 30 prior to the report. The report shall
21 include suggested legislation for consideration by the General
22 Assembly. The filing of one copy of the report with the
23 Speaker, one copy with the Minority Leader and one copy with
24 the Clerk of the House of Representatives, one copy with the
25 President, one copy with the Minority Leader and one copy with
26 the Secretary of the Senate, one copy with the Legislative

1 Research Unit, and such additional copies with the State
2 Government Report Distribution Center for the General Assembly
3 as is required under paragraph (t) of Section 7 of the State
4 Library Act shall be deemed sufficient to comply with this
5 Section.

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

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

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

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

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

18 On or after July 1, 2015, opioid antagonists prescribed for
19 the treatment of an opioid overdose, including the medication
20 product, administration devices, and any pharmacy fees related
21 to the dispensing and administration of the opioid antagonist,
22 shall be covered under the medical assistance program for
23 persons who are otherwise eligible for medical assistance under
24 this Article. As used in this Section, "opioid antagonist"
25 means a drug that binds to opioid receptors and blocks or
26 inhibits the effect of opioids acting on those receptors,

1 including, but not limited to, naloxone hydrochloride or any
2 other similarly acting drug approved by the U.S. Food and Drug
3 Administration.

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

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

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

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

1 treatment of sickle cell anemia; and (17) any other medical
2 care, and any other type of remedial care recognized under the
3 laws of this State, but not including abortions, or induced
4 miscarriages or premature births, unless, in the opinion of a
5 physician, such procedures are necessary for the preservation
6 of the life of the woman seeking such treatment, or except an
7 induced premature birth intended to produce a live viable child
8 and such procedure is necessary for the health of the mother or
9 her unborn child. The Illinois Department, by rule, shall
10 prohibit any physician from providing medical assistance to
11 anyone eligible therefor under this Code where such physician
12 has been found guilty of performing an abortion procedure in a
13 wilful and wanton manner upon a woman who was not pregnant at
14 the time such abortion procedure was performed. The term "any
15 other type of remedial care" shall include nursing care and
16 nursing home service for persons who rely on treatment by
17 spiritual means alone through prayer for healing.

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

25 Notwithstanding any other provision of this Code, the
26 Illinois Department may not require, as a condition of payment

1 for any laboratory test authorized under this Article, that a
2 physician's handwritten signature appear on the laboratory
3 test order form. The Illinois Department may, however, impose
4 other appropriate requirements regarding laboratory test order
5 documentation.

6 Notwithstanding any other provision of this Code, the
7 Department shall provide medical assistance coverage for
8 diabetes education provided by a certified diabetes education
9 provider for children with Type 1 diabetes who are under the
10 age of 18. For purposes of this paragraph:

11 "Certified diabetes education provider" means a
12 professional who has undergone training and certification
13 under conditions approved by the American Association of
14 Diabetes Educators or a successor association of
15 professionals.

16 "Type 1 diabetes" shall have the same meaning ascribed
17 to it by the American Diabetes Association or any successor
18 association.

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

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

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

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

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

22 Notwithstanding any other provision of this Code and
23 subject to federal approval, the Department may adopt rules to
24 allow a dentist who is volunteering his or her service at no
25 cost to render dental services through an enrolled
26 not-for-profit health clinic without the dentist personally

1 enrolling as a participating provider in the medical assistance
2 program. A not-for-profit health clinic shall include a public
3 health clinic or Federally Qualified Health Center or other
4 enrolled provider, as determined by the Department, through
5 which dental services covered under this Section are performed.
6 The Department shall establish a process for payment of claims
7 for reimbursement for covered dental services rendered under
8 this provision.

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

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

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

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

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

1 older.

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

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

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

15 All screenings shall include a physical breast exam,
16 instruction on self-examination and information regarding the
17 frequency of self-examination and its value as a preventative
18 tool. For purposes of this Section, "low-dose mammography"
19 means the x-ray examination of the breast using equipment
20 dedicated specifically for mammography, including the x-ray
21 tube, filter, compression device, and image receptor, with an
22 average radiation exposure delivery of less than one rad per
23 breast for 2 views of an average size breast. The term also
24 includes digital mammography and includes breast
25 tomosynthesis. As used in this Section, the term "breast
26 tomosynthesis" means a radiologic procedure that involves the

1 acquisition of projection images over the stationary breast to
2 produce cross-sectional digital three-dimensional images of
3 the breast.

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

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

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

17 On and after January 1, 2017, providers participating in a
18 breast cancer treatment quality improvement program approved
19 by the Department shall be reimbursed for breast cancer
20 treatment at a rate that is no lower than 95% of the Medicare
21 program's rates for the data elements included in the breast
22 cancer treatment quality program.

23 The Department shall convene an expert panel, including
24 representatives of hospitals, free standing breast cancer
25 treatment centers, breast cancer quality organizations, and
26 doctors, including breast surgeons, reconstructive breast

1 surgeons, oncologists, and primary care providers to establish
2 quality standards for breast cancer treatment.

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

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

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

25 The Department shall devise a means of case-managing or
26 patient navigation for beneficiaries diagnosed with breast

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

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

21 Any medical or health care provider shall immediately
22 recommend, to any pregnant woman who is being provided prenatal
23 services and is suspected of drug abuse or is addicted as
24 defined in the Alcoholism and Other Drug Abuse and Dependency
25 Act, referral to a local substance abuse treatment provider
26 licensed by the Department of Human Services or to a licensed

1 hospital which provides substance abuse treatment services.
2 The Department of Healthcare and Family Services shall assure
3 coverage for the cost of treatment of the drug abuse or
4 addiction for pregnant recipients in accordance with the
5 Illinois Medicaid Program in conjunction with the Department of
6 Human Services.

7 All medical providers providing medical assistance to
8 pregnant women under this Code shall receive information from
9 the Department on the availability of services under the Drug
10 Free Families with a Future or any comparable program providing
11 case management services for addicted women, including
12 information on appropriate referrals for other social services
13 that may be needed by addicted women in addition to treatment
14 for addiction.

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

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

26 The Illinois Department shall establish such regulations

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

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

18 The sponsor must negotiate formal written contracts with
19 medical providers for physician services, inpatient and
20 outpatient hospital care, home health services, treatment for
21 alcoholism and substance abuse, and other services determined
22 necessary by the Illinois Department by rule for delivery by
23 Partnerships. Physician services must include prenatal and
24 obstetrical care. The Illinois Department shall reimburse
25 medical services delivered by Partnership providers to clients
26 in target areas according to provisions of this Article and the

1 Illinois Health Finance Reform Act, except that:

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

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

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

14 Medical providers shall be required to meet certain
15 qualifications to participate in Partnerships to ensure the
16 delivery of high quality medical services. These
17 qualifications shall be determined by rule of the Illinois
18 Department and may be higher than qualifications for
19 participation in the medical assistance program. Partnership
20 sponsors may prescribe reasonable additional qualifications
21 for participation by medical providers, only with the prior
22 written approval of the Illinois Department.

23 Nothing in this Section shall limit the free choice of
24 practitioners, hospitals, and other providers of medical
25 services by clients. In order to ensure patient freedom of
26 choice, the Illinois Department shall immediately promulgate

1 all rules and take all other necessary actions so that provided
2 services may be accessed from therapeutically certified
3 optometrists to the full extent of the Illinois Optometric
4 Practice Act of 1987 without discriminating between service
5 providers.

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

9 The Illinois Department shall require health care
10 providers to maintain records that document the medical care
11 and services provided to recipients of Medical Assistance under
12 this Article. Such records must be retained for a period of not
13 less than 6 years from the date of service or as provided by
14 applicable State law, whichever period is longer, except that
15 if an audit is initiated within the required retention period
16 then the records must be retained until the audit is completed
17 and every exception is resolved. The Illinois Department shall
18 require health care providers to make available, when
19 authorized by the patient, in writing, the medical records in a
20 timely fashion to other health care providers who are treating
21 or serving persons eligible for Medical Assistance under this
22 Article. All dispensers of medical services shall be required
23 to maintain and retain business and professional records
24 sufficient to fully and accurately document the nature, scope,
25 details and receipt of the health care provided to persons
26 eligible for medical assistance under this Code, in accordance

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

23 The rules and regulations of the Illinois Department shall
24 require that a written statement including the required opinion
25 of a physician shall accompany any claim for reimbursement for
26 abortions, or induced miscarriages or premature births. This

1 statement shall indicate what procedures were used in providing
2 such medical services.

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

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

24 The Illinois Department shall require all dispensers of
25 medical services, other than an individual practitioner or
26 group of practitioners, desiring to participate in the Medical

1 Assistance program established under this Article to disclose
2 all financial, beneficial, ownership, equity, surety or other
3 interests in any and all firms, corporations, partnerships,
4 associations, business enterprises, joint ventures, agencies,
5 institutions or other legal entities providing any form of
6 health care services in this State under this Article.

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

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

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

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

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

23 To be eligible for payment consideration, a vendor's
24 payment claim or bill, either as an initial claim or as a
25 resubmitted claim following prior rejection, must be received
26 by the Illinois Department, or its fiscal intermediary, no

1 later than 180 days after the latest date on the claim on which
2 medical goods or services were provided, with the following
3 exceptions:

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

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

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

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

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

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

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

26 Beginning in fiscal year 2013, the Illinois Department

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

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

1 replacements of any device or equipment previously authorized
2 for such recipient by the Department.

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

1 workgroup that includes affected agency representatives and
2 stakeholders representing the institutional and home and
3 community-based long term care interests. This Section shall
4 not restrict the Department from implementing lower level of
5 care eligibility criteria for community-based services in
6 circumstances where federal approval has been granted.

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

14 The Illinois Department shall report annually to the
15 General Assembly, no later than the second Friday in April of
16 1979 and each year thereafter, in regard to:

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

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

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

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

25 The period covered by each report shall be the 3 years
26 ending on the June 30 prior to the report. The report shall

1 include suggested legislation for consideration by the General
2 Assembly. The filing of one copy of the report with the
3 Speaker, one copy with the Minority Leader and one copy with
4 the Clerk of the House of Representatives, one copy with the
5 President, one copy with the Minority Leader and one copy with
6 the Secretary of the Senate, one copy with the Legislative
7 Research Unit, and such additional copies with the State
8 Government Report Distribution Center for the General Assembly
9 as is required under paragraph (t) of Section 7 of the State
10 Library Act shall be deemed sufficient to comply with this
11 Section.

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

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

23 Because kidney transplantation can be an appropriate, cost
24 effective alternative to renal dialysis when medically
25 necessary and notwithstanding the provisions of Section 1-11 of
26 this Code, beginning October 1, 2014, the Department shall

1 cover kidney transplantation for noncitizens with end-stage
2 renal disease who are not eligible for comprehensive medical
3 benefits, who meet the residency requirements of Section 5-3 of
4 this Code, and who would otherwise meet the financial
5 requirements of the appropriate class of eligible persons under
6 Section 5-2 of this Code. To qualify for coverage of kidney
7 transplantation, such person must be receiving emergency renal
8 dialysis services covered by the Department. Providers under
9 this Section shall be prior approved and certified by the
10 Department to perform kidney transplantation and the services
11 under this Section shall be limited to services associated with
12 kidney transplantation.

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

24 On or after July 1, 2015, opioid antagonists prescribed for
25 the treatment of an opioid overdose, including the medication
26 product, administration devices, and any pharmacy fees related

1 to the dispensing and administration of the opioid antagonist,
2 shall be covered under the medical assistance program for
3 persons who are otherwise eligible for medical assistance under
4 this Article. As used in this Section, "opioid antagonist"
5 means a drug that binds to opioid receptors and blocks or
6 inhibits the effect of opioids acting on those receptors,
7 including, but not limited to, naloxone hydrochloride or any
8 other similarly acting drug approved by the U.S. Food and Drug
9 Administration.

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

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

24 Section 99. Effective date. This Act takes effect upon
25 becoming law.