

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 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. Notwithstanding any
10 provision of Section 5-5f to the contrary, the Department may,
11 by rule, exempt certain replacement wheelchair parts from prior
12 approval and, for wheelchairs, wheelchair parts, wheelchair
13 accessories, and related seating and positioning items,
14 determine the wholesale price by methods other than actual
15 acquisition costs.

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

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

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

1 circumstances where federal approval has been granted.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 inhibits the effect of opioids acting on those receptors,
2 including, but not limited to, naloxone hydrochloride or any
3 other similarly acting drug approved by the U.S. Food and Drug
4 Administration.

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

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

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

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

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

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

26 Notwithstanding any other provision of this Code, the

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

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

25 On and after July 1, 2012, the Department of Healthcare and
26 Family Services may provide the following services to persons

1 eligible for assistance under this Article who are
2 participating in education, training or employment programs
3 operated by the Department of Human Services as successor to
4 the Department of Public Aid:

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

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

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

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

26 The Department of Healthcare and Family Services must

1 provide coverage and reimbursement for amino acid-based
2 elemental formulas, regardless of delivery method, for the
3 diagnosis and treatment of (i) eosinophilic disorders and (ii)
4 short bowel syndrome when the prescribing physician has issued
5 a written order stating that the amino acid-based elemental
6 formula is medically necessary.

7 The Illinois Department shall authorize the provision of,
8 and shall authorize payment for, screening by low-dose
9 mammography for the presence of occult breast cancer for women
10 35 years of age or older who are eligible for medical
11 assistance under this Article, as follows:

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

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

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

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

26 (E) A screening MRI when medically necessary, as

1 determined by a physician licensed to practice medicine in
2 all of its branches.

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

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

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

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

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

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

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

24 The Department shall establish a methodology to remind
25 women who are age-appropriate for screening mammography, but
26 who have not received a mammogram within the previous 18

1 months, of the importance and benefit of screening mammography.
2 The Department shall work with experts in breast cancer
3 outreach and patient navigation to optimize these reminders and
4 shall establish a methodology for evaluating their
5 effectiveness and modifying the methodology based on the
6 evaluation.

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

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

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

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

21 All medical providers providing medical assistance to
22 pregnant women under this Code shall receive information from
23 the Department on the availability of services under the Drug
24 Free Families with a Future or any comparable program providing
25 case management services for addicted women, including
26 information on appropriate referrals for other social services

1 that may be needed by addicted women in addition to treatment
2 for addiction.

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

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

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

23 The Illinois Department may develop and contract with
24 Partnerships of medical providers to arrange medical services
25 for persons eligible under Section 5-2 of this Code.
26 Implementation of this Section may be by demonstration projects

1 in certain geographic areas. The Partnership shall be
2 represented by a sponsor organization. The Department, by rule,
3 shall develop qualifications for sponsors of Partnerships.
4 Nothing in this Section shall be construed to require that the
5 sponsor organization be a medical organization.

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

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

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

24 (3) Persons receiving medical services through
25 Partnerships may receive medical and case management
26 services above the level usually offered through the

1 medical assistance program.

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

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

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

23 The Illinois Department shall require health care
24 providers to maintain records that document the medical care
25 and services provided to recipients of Medical Assistance under
26 this Article. Such records must be retained for a period of not

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

1 is being made are actually being received by eligible
2 recipients. Within 90 days after September 16, 1984 (the
3 effective date of Public Act 83-1439) ~~this amendatory Act of~~
4 ~~1984~~, the Illinois Department shall establish a current list of
5 acquisition costs for all prosthetic devices and any other
6 items recognized as medical equipment and supplies
7 reimbursable under this Article and shall update such list on a
8 quarterly basis, except that the acquisition costs of all
9 prescription drugs shall be updated no less frequently than
10 every 30 days as required by Section 5-5.12.

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

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

1 home claims.

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

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

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

1 inquiries could indicate potential existence of claims or liens
2 for the Illinois Department.

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

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

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

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

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

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

23 (2) In the case of errors attributable to the Illinois
24 Department or any of its claims processing intermediaries
25 which result in an inability to receive, process, or
26 adjudicate a claim, the 180-day period shall not begin

1 until the provider has been notified of the error.

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

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

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

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

1 accepted transaction shall be retained by a facility to verify
2 timely submittal. Once an admission transaction has been
3 completed, all resubmitted claims following prior rejection
4 are subject to receipt no later than 180 days after the
5 admission transaction has been completed.

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

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

24 The Illinois Department shall enter into agreements with
25 State agencies and departments, and is authorized to enter into
26 agreements with federal agencies and departments, under which

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

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

1 take any action or acquire any products or services.

2 The Illinois Department shall establish policies,
3 procedures, standards and criteria by rule for the acquisition,
4 repair and replacement of orthotic and prosthetic devices and
5 durable medical equipment. Such rules shall provide, but not be
6 limited to, the following services: (1) immediate repair or
7 replacement of such devices by recipients; and (2) rental,
8 lease, purchase or lease-purchase of durable medical equipment
9 in a cost-effective manner, taking into consideration the
10 recipient's medical prognosis, the extent of the recipient's
11 needs, and the requirements and costs for maintaining such
12 equipment. Subject to prior approval, such rules shall enable a
13 recipient to temporarily acquire and use alternative or
14 substitute devices or equipment pending repairs or
15 replacements of any device or equipment previously authorized
16 for such recipient by the Department. Notwithstanding any
17 provision of Section 5-5f to the contrary, the Department may,
18 by rule, exempt certain replacement wheelchair parts from prior
19 approval and, for wheelchairs, wheelchair parts, wheelchair
20 accessories, and related seating and positioning items,
21 determine the wholesale price by methods other than actual
22 acquisition costs.

23 The Department shall require, by rule, all providers of
24 durable medical equipment to be accredited by an accreditation
25 organization approved by the federal Centers for Medicare and
26 Medicaid Services and recognized by the Department in order to

1 bill the Department for providing durable medical equipment to
2 recipients. No later than 15 months after the effective date of
3 the rule adopted pursuant to this paragraph, all providers must
4 meet the accreditation requirement.

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

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

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

16 The Illinois Department shall report annually to the
17 General Assembly, no later than the second Friday in April of
18 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

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

25 Because kidney transplantation can be an appropriate, cost
26 effective alternative to renal dialysis when medically

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

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

26 On or after July 1, 2015, opioid antagonists prescribed for

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

12 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
13 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
14 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
15 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
16 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
17 99 of P.A. 99-407 for its effective date); 99-433, eff.
18 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

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