



Rep. Elizabeth Hernandez

Filed: 3/13/2017

10000HB1803ham002

LRB100 07998 KTG 23077 a

1 AMENDMENT TO HOUSE BILL 1803

2 AMENDMENT NO. _____. Amend House Bill 1803 by replacing
3 everything after the enacting clause with the following:

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 Sec. 5-5. Medical services. The Illinois Department, by
8 rule, shall determine the quantity and quality of and the rate
9 of reimbursement for the medical assistance for which payment
10 will be authorized, and the medical services to be provided,
11 which may include all or part of the following: (1) inpatient
12 hospital services; (2) outpatient hospital services; (3) other
13 laboratory and X-ray services; (4) skilled nursing home
14 services; (5) physicians' services whether furnished in the
15 office, the patient's home, a hospital, a skilled nursing home,
16 or elsewhere; (6) medical care, or any other type of remedial

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

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

23 Notwithstanding any other provision of this Section, a
24 comprehensive tobacco use cessation program that includes
25 purchasing prescription drugs or prescription medical devices
26 approved by the Food and Drug Administration shall be covered

1 under the medical assistance program under this Article for
2 persons who are otherwise eligible for assistance under this
3 Article.

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

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

1 payment and shall be reimbursed at the Department's or the
2 MCE's established rates or rate methodologies for eyeglasses.

3 On and after July 1, 2012, the Department of Healthcare and
4 Family Services may provide the following services to persons
5 eligible for assistance under this Article who are
6 participating in education, training or employment programs
7 operated by the Department of Human Services as successor to
8 the Department of Public Aid:

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

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

14 On and after July 1, 2017, the Department of Healthcare and
15 Family Services shall provide dental services to any adult who
16 is otherwise eligible for assistance under the medical
17 assistance program. As used in this paragraph, "dental
18 services" means diagnostic, preventative, restorative, or
19 corrective procedures, including procedures and services for
20 the prevention and treatment of periodontal disease and dental
21 caries disease, provided by an individual who is licensed to
22 practice dentistry or dental surgery or who is under the
23 supervision of a dentist in the practice of his or her
24 profession.

25 On and after July 1, 2017, targeted dental services, as set
26 forth in Exhibit D of the Consent Decree entered by the United

1 States District Court for the Northern District of Illinois,
2 Eastern Division, in the matter of Memisovski v. Maram, Case
3 No. 92 C 1982, that are provided to adults under the medical
4 assistance program shall be reimbursed at the rates set forth
5 in the "New Rate" column in Exhibit D of the Consent Decree for
6 targeted dental services that are provided to persons under the
7 age of 18 under the medical assistance program.

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

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

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

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

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

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

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

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

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

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

1 All screenings shall include a physical breast exam,
2 instruction on self-examination and information regarding the
3 frequency of self-examination and its value as a preventative
4 tool. For purposes of this Section, "low-dose mammography"
5 means the x-ray examination of the breast using equipment
6 dedicated specifically for mammography, including the x-ray
7 tube, filter, compression device, and image receptor, with an
8 average radiation exposure delivery of less than one rad per
9 breast for 2 views of an average size breast. The term also
10 includes digital mammography and includes breast
11 tomosynthesis. As used in this Section, the term "breast
12 tomosynthesis" means a radiologic procedure that involves the
13 acquisition of projection images over the stationary breast to
14 produce cross-sectional digital three-dimensional images of
15 the breast. If, at any time, the Secretary of the United States
16 Department of Health and Human Services, or its successor
17 agency, promulgates rules or regulations to be published in the
18 Federal Register or publishes a comment in the Federal Register
19 or issues an opinion, guidance, or other action that would
20 require the State, pursuant to any provision of the Patient
21 Protection and Affordable Care Act (Public Law 111-148),
22 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
23 successor provision, to defray the cost of any coverage for
24 breast tomosynthesis outlined in this paragraph, then the
25 requirement that an insurer cover breast tomosynthesis is
26 inoperative other than any such coverage authorized under

1 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
2 the State shall not assume any obligation for the cost of
3 coverage for breast tomosynthesis set forth in this paragraph.

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), the Illinois Department
16 shall establish a current list of acquisition costs for all
17 prosthetic devices and any other items recognized as medical
18 equipment and supplies reimbursable under this Article and
19 shall update such list on a quarterly basis, except that the
20 acquisition costs of all prescription drugs shall be updated no
21 less frequently than every 30 days as required by Section
22 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. Notwithstanding any
3 provision of Section 5-5f to the contrary, the Department may,
4 by rule, exempt certain replacement wheelchair parts from prior
5 approval and, for wheelchairs, wheelchair parts, wheelchair
6 accessories, and related seating and positioning items,
7 determine the wholesale price by methods other than actual
8 acquisition costs.

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

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

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

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

1 assistance under this Code.

2 The Illinois Department shall report annually to the
3 General Assembly, no later than the second Friday in April of
4 1979 and each year thereafter, in regard to:

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

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

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

11 (d) efforts at utilization review and control by the
12 Illinois Department.

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

26 Rulemaking authority to implement Public Act 95-1045, if

1 any, is conditioned on the rules being adopted in accordance
2 with all provisions of the Illinois Administrative Procedure
3 Act and all rules and procedures of the Joint Committee on
4 Administrative Rules; any purported rule not so adopted, for
5 whatever reason, is unauthorized.

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

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

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

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

24 Upon federal approval, the Department shall provide
25 coverage and reimbursement for all drugs that are approved for
26 marketing by the federal Food and Drug Administration and that

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

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 20 of P.A. 99-588 for the effective date of P.A. 99-407);
16 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff.
17 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895,
18 eff. 1-1-17; revised 9-20-16.)

19 Section 99. Effective date. This Act takes effect upon
20 becoming law."