

1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by
5 changing Section 356z.22 as follows:

6 (215 ILCS 5/356z.22)

7 Sec. 356z.22. Coverage for telehealth services.

8 (a) For purposes of this Section:

9 "Distant site" means the location at which the health care
10 provider rendering the telehealth service is located.

11 "Interactive telecommunications system" means an audio and
12 video system permitting 2-way, live interactive communication
13 between the patient and the distant site health care provider.

14 "Telehealth services" means the delivery of covered health
15 care services by way of an interactive telecommunications
16 system.

17 (b) If an individual or group policy of accident or health
18 insurance provides coverage for telehealth services, then it
19 must comply with the following:

20 (1) An individual or group policy of accident or health
21 insurance providing telehealth services may not:

22 (A) require that in-person contact occur between a
23 health care provider and a patient;

1 (B) require the health care provider to document a
2 barrier to an in-person consultation for coverage of
3 services to be provided through telehealth;

4 (C) require the use of telehealth when the health
5 care provider has determined that it is not
6 appropriate; or

7 (D) require the use of telehealth when a patient
8 chooses an in-person consultation.

9 (2) Deductibles, copayments, or coinsurance applicable
10 to services provided through telehealth shall not exceed
11 the deductibles, copayments, or coinsurance required by
12 the individual or group policy of accident or health
13 insurance for the same services provided through in-person
14 consultation.

15 (b-5) If an individual or group policy of accident or
16 health insurance provides coverage for telehealth services, it
17 must provide coverage for licensed dietitian nutritionists and
18 certified diabetes educators who counsel senior diabetes
19 patients in the senior diabetes patients' homes to remove the
20 hurdle of transportation for senior diabetes patients to
21 receive treatment.

22 (c) Nothing in this Section shall be deemed as precluding a
23 health insurer from providing benefits for other services,
24 including, but not limited to, remote monitoring services,
25 other monitoring services, or oral communications otherwise
26 covered under the policy.

1 (Source: P.A. 98-1091, eff. 1-1-15.)

2 Section 10. The Illinois Public Aid Code is amended by
3 changing Section 5-5 as follows:

4 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

1 prosthetic devices; and eyeglasses prescribed by a physician
2 skilled in the diseases of the eye, or by an optometrist,
3 whichever the person may select; (13) other diagnostic,
4 screening, preventive, and rehabilitative services, including
5 to ensure that the individual's need for intervention or
6 treatment of mental disorders or substance use disorders or
7 co-occurring mental health and substance use disorders is
8 determined using a uniform screening, assessment, and
9 evaluation process inclusive of criteria, for children and
10 adults; for purposes of this item (13), a uniform screening,
11 assessment, and evaluation process refers to a process that
12 includes an appropriate evaluation and, as warranted, a
13 referral; "uniform" does not mean the use of a singular
14 instrument, tool, or process that all must utilize; (14)
15 transportation and such other expenses as may be necessary;
16 (15) medical treatment of sexual assault survivors, as defined
17 in Section 1a of the Sexual Assault Survivors Emergency
18 Treatment Act, for injuries sustained as a result of the sexual
19 assault, including examinations and laboratory tests to
20 discover evidence which may be used in criminal proceedings
21 arising from the sexual assault; (16) the diagnosis and
22 treatment of sickle cell anemia; and (17) any other medical
23 care, and any other type of remedial care recognized under the
24 laws of this State. The term "any other type of remedial care"
25 shall include nursing care and nursing home service for persons
26 who rely on treatment by spiritual means alone through prayer

1 for healing.

2 Notwithstanding any other provision of this Section, a
3 comprehensive tobacco use cessation program that includes
4 purchasing prescription drugs or prescription medical devices
5 approved by the Food and Drug Administration shall be covered
6 under the medical assistance program under this Article for
7 persons who are otherwise eligible for assistance under this
8 Article.

9 Notwithstanding any other provision of this Code,
10 reproductive health care that is otherwise legal in Illinois
11 shall be covered under the medical assistance program for
12 persons who are otherwise eligible for medical assistance under
13 this Article.

14 Notwithstanding any other provision of this Code, the
15 Illinois Department may not require, as a condition of payment
16 for any laboratory test authorized under this Article, that a
17 physician's handwritten signature appear on the laboratory
18 test order form. The Illinois Department may, however, impose
19 other appropriate requirements regarding laboratory test order
20 documentation.

21 Upon receipt of federal approval of an amendment to the
22 Illinois Title XIX State Plan for this purpose, the Department
23 shall authorize the Chicago Public Schools (CPS) to procure a
24 vendor or vendors to manufacture eyeglasses for individuals
25 enrolled in a school within the CPS system. CPS shall ensure
26 that its vendor or vendors are enrolled as providers in the

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

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

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

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

24 Notwithstanding any other provision of this Code and
25 subject to federal approval, the Department may adopt rules to
26 allow a dentist who is volunteering his or her service at no

1 cost to render dental services through an enrolled
2 not-for-profit health clinic without the dentist personally
3 enrolling as a participating provider in the medical assistance
4 program. A not-for-profit health clinic shall include a public
5 health clinic or Federally Qualified Health Center or other
6 enrolled provider, as determined by the Department, through
7 which dental services covered under this Section are performed.
8 The Department shall establish a process for payment of claims
9 for reimbursement for covered dental services rendered under
10 this provision.

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

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

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

26 (A) A baseline mammogram for women 35 to 39 years of

1 age.

2 (B) An annual mammogram for women 40 years of age or
3 older.

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

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

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

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

1 tomosynthesis. As used in this Section, the term "breast
2 tomosynthesis" means a radiologic procedure that involves the
3 acquisition of projection images over the stationary breast to
4 produce cross-sectional digital three-dimensional images of
5 the breast. If, at any time, the Secretary of the United States
6 Department of Health and Human Services, or its successor
7 agency, promulgates rules or regulations to be published in the
8 Federal Register or publishes a comment in the Federal Register
9 or issues an opinion, guidance, or other action that would
10 require the State, pursuant to any provision of the Patient
11 Protection and Affordable Care Act (Public Law 111-148),
12 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
13 successor provision, to defray the cost of any coverage for
14 breast tomosynthesis outlined in this paragraph, then the
15 requirement that an insurer cover breast tomosynthesis is
16 inoperative other than any such coverage authorized under
17 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
18 the State shall not assume any obligation for the cost of
19 coverage for breast tomosynthesis set forth in this paragraph.

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

24 On and after January 1, 2012, providers participating in a
25 quality improvement program approved by the Department shall be
26 reimbursed for screening and diagnostic mammography at the same

1 rate as the Medicare program's rates, including the increased
2 reimbursement for digital mammography.

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

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

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

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

26 The Department shall establish a methodology to remind

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

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

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

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

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

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

23 All medical providers providing medical assistance to
24 pregnant women under this Code shall receive information from
25 the Department on the availability of services under the Drug
26 Free Families with a Future or any comparable program providing

1 case management services for addicted women, including
2 information on appropriate referrals for other social services
3 that may be needed by addicted women in addition to treatment
4 for addiction.

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

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

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

25 The Illinois Department may develop and contract with
26 Partnerships of medical providers to arrange medical services

1 for persons eligible under Section 5-2 of this Code.
2 Implementation of this Section may be by demonstration projects
3 in certain geographic areas. The Partnership shall be
4 represented by a sponsor organization. The Department, by rule,
5 shall develop qualifications for sponsors of Partnerships.
6 Nothing in this Section shall be construed to require that the
7 sponsor organization be a medical organization.

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

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

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

26 (3) Persons receiving medical services through

1 Partnerships may receive medical and case management
2 services above the level usually offered through the
3 medical assistance program.

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

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

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

25 The Illinois Department shall require health care
26 providers to maintain records that document the medical care

1 and services provided to recipients of Medical Assistance under
2 this Article. Such records must be retained for a period of not
3 less than 6 years from the date of service or as provided by
4 applicable State law, whichever period is longer, except that
5 if an audit is initiated within the required retention period
6 then the records must be retained until the audit is completed
7 and every exception is resolved. The Illinois Department shall
8 require health care providers to make available, when
9 authorized by the patient, in writing, the medical records in a
10 timely fashion to other health care providers who are treating
11 or serving persons eligible for Medical Assistance under this
12 Article. All dispensers of medical services shall be required
13 to maintain and retain business and professional records
14 sufficient to fully and accurately document the nature, scope,
15 details and receipt of the health care provided to persons
16 eligible for medical assistance under this Code, in accordance
17 with regulations promulgated by the Illinois Department. The
18 rules and regulations shall require that proof of the receipt
19 of prescription drugs, dentures, prosthetic devices and
20 eyeglasses by eligible persons under this Section accompany
21 each claim for reimbursement submitted by the dispenser of such
22 medical services. No such claims for reimbursement shall be
23 approved for payment by the Illinois Department without such
24 proof of receipt, unless the Illinois Department shall have put
25 into effect and shall be operating a system of post-payment
26 audit and review which shall, on a sampling basis, be deemed

1 adequate by the Illinois Department to assure that such drugs,
2 dentures, prosthetic devices and eyeglasses for which payment
3 is being made are actually being received by eligible
4 recipients. Within 90 days after September 16, 1984 (the
5 effective date of Public Act 83-1439), the Illinois Department
6 shall establish a current list of acquisition costs for all
7 prosthetic devices and any other items recognized as medical
8 equipment and supplies reimbursable under this Article and
9 shall update such list on a quarterly basis, except that the
10 acquisition costs of all prescription drugs shall be updated no
11 less frequently than every 30 days as required by Section
12 5-5.12.

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

24 Notwithstanding any other law to the contrary, the Illinois
25 Department shall, within 365 days after August 15, 2014 (the
26 effective date of Public Act 98-963), establish procedures to

1 permit ID/DD facilities licensed under the ID/DD Community Care
2 Act and MC/DD facilities licensed under the MC/DD Act to submit
3 monthly billing claims for reimbursement purposes. Following
4 development of these procedures, the Department shall have an
5 additional 365 days to test the viability of the new system and
6 to ensure that any necessary operational or structural changes
7 to its information technology platforms are implemented.

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

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

25 Enrollment of a vendor shall be subject to a provisional
26 period and shall be conditional for one year. During the period

1 of conditional enrollment, the Department may terminate the
2 vendor's eligibility to participate in, or may disenroll the
3 vendor from, the medical assistance program without cause.
4 Unless otherwise specified, such termination of eligibility or
5 disenrollment is not subject to the Department's hearing
6 process. However, a disenrolled vendor may reapply without
7 penalty.

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

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

23 The Department shall define or specify the following: (i)
24 by provider notice, the "category of risk of the vendor" for
25 each type of vendor, which shall take into account the level of
26 screening applicable to a particular category of vendor under

1 federal law and regulations; (ii) by rule or provider notice,
2 the maximum length of the conditional enrollment period for
3 each category of risk of the vendor; and (iii) by rule, the
4 hearing rights, if any, afforded to a vendor in each category
5 of risk of the vendor that is terminated or disenrolled during
6 the conditional enrollment period.

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

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

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

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

26 (4) In the case of a provider operated by a unit of

1 local government with a population exceeding 3,000,000
2 when local government funds finance federal participation
3 for claims payments.

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

11 In the case of long term care facilities, within 45
12 calendar days of receipt by the facility of required
13 prescreening information, new admissions with associated
14 admission documents shall be submitted through the Medical
15 Electronic Data Interchange (MEDI) or the Recipient
16 Eligibility Verification (REV) System or shall be submitted
17 directly to the Department of Human Services using required
18 admission forms. Effective September 1, 2014, admission
19 documents, including all prescreening information, must be
20 submitted through MEDI or REV. Confirmation numbers assigned to
21 an accepted transaction shall be retained by a facility to
22 verify timely submittal. Once an admission transaction has been
23 completed, all resubmitted claims following prior rejection
24 are subject to receipt no later than 180 days after the
25 admission transaction has been completed.

26 Claims that are not submitted and received in compliance

1 with the foregoing requirements shall not be eligible for
2 payment under the medical assistance program, and the State
3 shall have no liability for payment of those claims.

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

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

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

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

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

1 replacement of such devices by recipients; and (2) rental,
2 lease, purchase or lease-purchase of durable medical equipment
3 in a cost-effective manner, taking into consideration the
4 recipient's medical prognosis, the extent of the recipient's
5 needs, and the requirements and costs for maintaining such
6 equipment. Subject to prior approval, such rules shall enable a
7 recipient to temporarily acquire and use alternative or
8 substitute devices or equipment pending repairs or
9 replacements of any device or equipment previously authorized
10 for such recipient by the Department. Notwithstanding any
11 provision of Section 5-5f to the contrary, the Department may,
12 by rule, exempt certain replacement wheelchair parts from prior
13 approval and, for wheelchairs, wheelchair parts, wheelchair
14 accessories, and related seating and positioning items,
15 determine the wholesale price by methods other than actual
16 acquisition costs.

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

25 The Department shall execute, relative to the nursing home
26 prescreening project, written inter-agency agreements with the

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

1 care eligibility criteria for community-based services in
2 circumstances where federal approval has been granted.

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

10 The Illinois Department shall report annually to the
11 General Assembly, no later than the second Friday in April of
12 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Upon federal approval, the Department shall provide
7 coverage and reimbursement for all drugs that are approved for
8 marketing by the federal Food and Drug Administration and that
9 are recommended by the federal Public Health Service or the
10 United States Centers for Disease Control and Prevention for
11 pre-exposure prophylaxis and related pre-exposure prophylaxis
12 services, including, but not limited to, HIV and sexually
13 transmitted infection screening, treatment for sexually
14 transmitted infections, medical monitoring, assorted labs, and
15 counseling to reduce the likelihood of HIV infection among
16 individuals who are not infected with HIV but who are at high
17 risk of HIV infection.

18 Notwithstanding any other provision of this Code, the
19 Illinois Department shall authorize licensed dietitian
20 nutritionists and certified diabetes educators to counsel
21 senior diabetes patients in the senior diabetes patients' homes
22 to remove the hurdle of transportation for senior diabetes
23 patients to receive treatment.

24 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
25 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
26 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;

1 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
2 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,
3 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
4 100-538, eff. 1-1-18; revised 10-26-17.)