

# SB0622



## 100TH GENERAL ASSEMBLY

### State of Illinois

2017 and 2018

SB0622

Introduced 1/24/2017, by Sen. Omar Aquino

#### SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

from Ch. 23, par. 5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. In a provision requiring the Department of Healthcare and Family Services to determine the quantity and quality of medical services provided under the State's Medical Assistance program, provides that such services may include dental and periodontal prevention and treatment services for residents of long term care facilities and adults diagnosed with a developmental disability or an acquired disability that is permanent and irreversible and that occurred prior to age 21. Provides that on or after July 1, 2017, the Department shall provide dental services, including periodontal prevention and treatment and prescription eyeglasses to veterans and their dependents. Effective immediately.

LRB100 05665 KTG 15682 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

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

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

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

7 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  
17 care furnished by licensed practitioners; (7) home health care  
18 services; (8) private duty nursing service; (9) clinic  
19 services; (10) dental services, including prevention and  
20 treatment of periodontal disease and dental caries disease for  
21 pregnant women, residents of long term care facilities, and  
22 adults diagnosed with a developmental disability or an acquired  
23 disability that is permanent and irreversible and that occurred

1 prior to age 21, 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 On or after July 1, 2017, the Department of Healthcare and  
11 Family Services shall provide the following services to any  
12 veteran and his or her dependents who are eligible for  
13 assistance under this Article if the veteran has served in a  
14 branch of the United States military for greater than 180 days  
15 after initial training and has not been dishonorably discharged  
16 from service:

17 (1) Dental services, including prevention and  
18 treatment of periodontal disease and dental caries  
19 disease, provided by an individual licensed to practice  
20 dentistry or dental surgery. As used in this paragraph (1),  
21 "dental services" means diagnostic, preventative, or  
22 corrective procedures provided by or under the supervision  
23 of a dentist in the practice of his or her profession.

24 (2) Eyeglasses prescribed by a physician skilled in  
25 diseases of the eye or by an optometrist, whomever the  
26 person may select.

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

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

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

24           The Illinois Department shall authorize the provision of,  
25 and shall authorize payment for, screening by low-dose  
26 mammography for the presence of occult breast cancer for women

1 35 years of age or older who are eligible for medical  
2 assistance under this Article, as follows:

3 (A) A baseline mammogram for women 35 to 39 years of  
4 age.

5 (B) An annual mammogram for women 40 years of age or  
6 older.

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

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

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

20 All screenings shall include a physical breast exam,  
21 instruction on self-examination and information regarding the  
22 frequency of self-examination and its value as a preventative  
23 tool. For purposes of this Section, "low-dose mammography"  
24 means the x-ray examination of the breast using equipment  
25 dedicated specifically for mammography, including the x-ray  
26 tube, filter, compression device, and image receptor, with an



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

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

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

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

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

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

22          Subject to federal approval, the Department shall  
23          establish a rate methodology for mammography at federally  
24          qualified health centers and other encounter-rate clinics.  
25          These clinics or centers may also collaborate with other  
26          hospital-based mammography facilities. By January 1, 2016, the

1 Department shall report to the General Assembly on the status  
2 of the provision set forth in this paragraph.

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

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

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

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

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

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

26 All medical providers providing medical assistance to

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

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

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

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

1 procedures to the Illinois Department.

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

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

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

26 (2) The Department may elect to consider and negotiate

1 financial incentives to encourage the development of  
2 Partnerships and the efficient delivery of medical care.

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

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

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

25 The Department shall apply for a waiver from the United  
26 States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.

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



1 proof of receipt, unless the Illinois Department shall have put  
2 into effect and shall be operating a system of post-payment  
3 audit and review which shall, on a sampling basis, be deemed  
4 adequate by the Illinois Department to assure that such drugs,  
5 dentures, prosthetic devices and eyeglasses for which payment  
6 is being made are actually being received by eligible  
7 recipients. Within 90 days after September 16, 1984 (the  
8 effective date of Public Act 83-1439), the Illinois Department  
9 shall establish a current list of acquisition costs for all  
10 prosthetic devices and any other items recognized as medical  
11 equipment and supplies reimbursable under this Article and  
12 shall update such list on a quarterly basis, except that the  
13 acquisition costs of all prescription drugs shall be updated no  
14 less frequently than every 30 days as required by Section  
15 5-5.12.

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

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

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

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

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

26 The Illinois Department may require that all dispensers of

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

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

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

20 Prior to enrollment and during the conditional enrollment  
21 period in the medical assistance program, all vendors shall be  
22 subject to enhanced oversight, screening, and review based on  
23 the risk of fraud, waste, and abuse that is posed by the  
24 category of risk of the vendor. The Illinois Department shall  
25 establish the procedures for oversight, screening, and review,  
26 which may include, but need not be limited to: criminal and

1 financial background checks; fingerprinting; license,  
2 certification, and authorization verifications; unscheduled or  
3 unannounced site visits; database checks; prepayment audit  
4 reviews; audits; payment caps; payment suspensions; and other  
5 screening as required by federal or State law.

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

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

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

1 complete.

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

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

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

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

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

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

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

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

1 exclusions; taxpayer identification numbers; tax delinquency;  
2 corporate information; and death records.

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

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

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

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



1 acquisition costs.

2 The Department shall require, by rule, all providers of  
3 durable medical equipment to be accredited by an accreditation  
4 organization approved by the federal Centers for Medicare and  
5 Medicaid Services and recognized by the Department in order to  
6 bill the Department for providing durable medical equipment to  
7 recipients. No later than 15 months after the effective date of  
8 the rule adopted pursuant to this paragraph, all providers must  
9 meet the accreditation requirement.

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

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

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

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

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

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

1 the various medical services by medical vendors;

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

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

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

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

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

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

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

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

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

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

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

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

3 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;  
4 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.  
5 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,  
6 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;  
7 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section  
8 20 of P.A. 99-588 for the effective date of P.A. 99-407);  
9 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff.  
10 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895,  
11 eff. 1-1-17; revised 9-20-16.)

12 Section 99. Effective date. This Act takes effect upon  
13 becoming law.