



Sen. Omar Aquino

**Filed: 2/15/2017**

10000SB0622sam001

LRB100 05665 KTG 22014 a

1 AMENDMENT TO SENATE BILL 622

2 AMENDMENT NO. \_\_\_\_\_. Amend Senate Bill 622 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 or after July 1, 2017, the Department of Healthcare and  
15 Family Services shall provide dental services to any person who  
16 is otherwise eligible for assistance under this Article and who  
17 is:

18 (1) a resident of a long term care facility;

19 (2) an adult diagnosed with a developmental disability  
20 or an acquired disability that is permanent and  
21 irreversible and that occurred prior to age 21; or

22 (3) a veteran who has served in a branch of the United  
23 States military for greater than 180 days after initial  
24 training and has not been dishonorably discharged from  
25 service and his or her dependents.

26 As used in this paragraph, "dental services" means

1 diagnostic, preventative, or corrective procedures, including  
2 procedures and services for the prevention and treatment of  
3 periodontal disease and dental caries disease, provided by an  
4 individual who is licensed to practice dentistry or dental  
5 surgery or who is under the supervision of a dentist in the  
6 practice of his or her profession.

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

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

23 The Department of Healthcare and Family Services must  
24 provide coverage and reimbursement for amino acid-based  
25 elemental formulas, regardless of delivery method, for the  
26 diagnosis and treatment of (i) eosinophilic disorders and (ii)

1 short bowel syndrome when the prescribing physician has issued  
2 a written order stating that the amino acid-based elemental  
3 formula is medically necessary.

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

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

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

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

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

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

26 All screenings shall include a physical breast exam,

1 instruction on self-examination and information regarding the  
2 frequency of self-examination and its value as a preventative  
3 tool. For purposes of this Section, "low-dose mammography"  
4 means the x-ray examination of the breast using equipment  
5 dedicated specifically for mammography, including the x-ray  
6 tube, filter, compression device, and image receptor, with an  
7 average radiation exposure delivery of less than one rad per  
8 breast for 2 views of an average size breast. The term also  
9 includes digital mammography and includes breast  
10 tomosynthesis. As used in this Section, the term "breast  
11 tomosynthesis" means a radiologic procedure that involves the  
12 acquisition of projection images over the stationary breast to  
13 produce cross-sectional digital three-dimensional images of  
14 the breast. If, at any time, the Secretary of the United States  
15 Department of Health and Human Services, or its successor  
16 agency, promulgates rules or regulations to be published in the  
17 Federal Register or publishes a comment in the Federal Register  
18 or issues an opinion, guidance, or other action that would  
19 require the State, pursuant to any provision of the Patient  
20 Protection and Affordable Care Act (Public Law 111-148),  
21 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any  
22 successor provision, to defray the cost of any coverage for  
23 breast tomosynthesis outlined in this paragraph, then the  
24 requirement that an insurer cover breast tomosynthesis is  
25 inoperative other than any such coverage authorized under  
26 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and



1 the State shall not assume any obligation for the cost of  
2 coverage for breast tomosynthesis set forth in this paragraph.

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

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

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

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

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

1 quality standards for breast cancer treatment.

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

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

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

24 The Department shall devise a means of case-managing or  
25 patient navigation for beneficiaries diagnosed with breast  
26 cancer. This program shall initially operate as a pilot program

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

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

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

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

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

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

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

25 The Illinois Department shall establish such regulations  
26 governing the dispensing of health services under this Article

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

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

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

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

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

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

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

22           Nothing in this Section shall limit the free choice of  
23 practitioners, hospitals, and other providers of medical  
24 services by clients. In order to ensure patient freedom of  
25 choice, the Illinois Department shall immediately promulgate  
26 all rules and take all other necessary actions so that provided

1 services may be accessed from therapeutically certified  
2 optometrists to the full extent of the Illinois Optometric  
3 Practice Act of 1987 without discriminating between service  
4 providers.

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

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

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

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



1 such medical services.

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

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

23 The Illinois Department shall require all dispensers of  
24 medical services, other than an individual practitioner or  
25 group of practitioners, desiring to participate in the Medical  
26 Assistance program established under this Article to disclose

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

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

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

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

26 Prior to enrollment and during the conditional enrollment

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

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

22 To be eligible for payment consideration, a vendor's  
23 payment claim or bill, either as an initial claim or as a  
24 resubmitted claim following prior rejection, must be received  
25 by the Illinois Department, or its fiscal intermediary, no  
26 later than 180 days after the latest date on the claim on which

1 medical goods or services were provided, with the following  
2 exceptions:

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

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

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

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

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

26 In the case of long term care facilities, within 5 days of

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

17 Claims that are not submitted and received in compliance  
18 with the foregoing requirements shall not be eligible for  
19 payment under the medical assistance program, and the State  
20 shall have no liability for payment of those claims.

21 To the extent consistent with applicable information and  
22 privacy, security, and disclosure laws, State and federal  
23 agencies and departments shall provide the Illinois Department  
24 access to confidential and other information and data necessary  
25 to perform eligibility and payment verifications and other  
26 Illinois Department functions. This includes, but is not

1 limited to: information pertaining to licensure;  
2 certification; earnings; immigration status; citizenship; wage  
3 reporting; unearned and earned income; pension income;  
4 employment; supplemental security income; social security  
5 numbers; National Provider Identifier (NPI) numbers; the  
6 National Practitioner Data Bank (NPDB); program and agency  
7 exclusions; taxpayer identification numbers; tax delinquency;  
8 corporate information; and death records.

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

25 Beginning in fiscal year 2013, the Illinois Department  
26 shall set forth a request for information to identify the

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

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

1 for such recipient by the Department. Notwithstanding any  
2 provision of Section 5-5f to the contrary, the Department may,  
3 by rule, exempt certain replacement wheelchair parts from prior  
4 approval and, for wheelchairs, wheelchair parts, wheelchair  
5 accessories, and related seating and positioning items,  
6 determine the wholesale price by methods other than actual  
7 acquisition costs.

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

16 The Department shall execute, relative to the nursing home  
17 prescreening project, written inter-agency agreements with the  
18 Department of Human Services and the Department on Aging, to  
19 effect the following: (i) intake procedures and common  
20 eligibility criteria for those persons who are receiving  
21 non-institutional services; and (ii) the establishment and  
22 development of non-institutional services in areas of the State  
23 where they are not currently available or are undeveloped; and  
24 (iii) notwithstanding any other provision of law, subject to  
25 federal approval, on and after July 1, 2012, an increase in the  
26 determination of need (DON) scores from 29 to 37 for applicants



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

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

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

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

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

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

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

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

25           Rulemaking authority to implement Public Act 95-1045, if  
26 any, is conditioned on the rules being adopted in accordance

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

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

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

26 Notwithstanding any other provision of this Code to the

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

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

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

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

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

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