



Rep. Kelly M. Cassidy

**Filed: 5/21/2018**

10000SB3048ham001

LRB100 18155 KTG 40493 a

1 AMENDMENT TO SENATE BILL 3048

2 AMENDMENT NO. \_\_\_\_\_. Amend Senate Bill 3048 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. The term "any other type of remedial care"  
9 shall include nursing care and nursing home service for persons  
10 who rely on treatment by spiritual means alone through prayer  
11 for healing.

12 Notwithstanding any other provision of this Section, a  
13 comprehensive tobacco use cessation program that includes  
14 purchasing prescription drugs or prescription medical devices  
15 approved by the Food and Drug Administration shall be covered  
16 under the medical assistance program under this Article for  
17 persons who are otherwise eligible for assistance under this  
18 Article.

19 Notwithstanding any other provision of this Code,  
20 reproductive health care that is otherwise legal in Illinois  
21 shall be covered under the medical assistance program for  
22 persons who are otherwise eligible for medical assistance under  
23 this Article.

24 Notwithstanding any other provision of this Code, the  
25 Illinois Department may not require, as a condition of payment  
26 for any laboratory test authorized under this Article, that a

1 physician's handwritten signature appear on the laboratory  
2 test order form. The Illinois Department may, however, impose  
3 other appropriate requirements regarding laboratory test order  
4 documentation.

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

23       On and after July 1, 2012, the Department of Healthcare and  
24 Family Services may provide the following services to persons  
25 eligible for assistance under this Article who are  
26 participating in education, training or employment programs

1 operated by the Department of Human Services as successor to  
2 the Department of Public Aid:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 surgeons, oncologists, and primary care providers to establish  
2 quality standards for breast cancer treatment.

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

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

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

25 The Department shall devise a means of case-managing or  
26 patient navigation for beneficiaries diagnosed with breast

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

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

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

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

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

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

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

26 The Illinois Department shall establish such regulations

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

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

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

1 Illinois Health Finance Reform Act, except that:

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

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

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

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

23 Nothing in this Section shall limit the free choice of  
24 practitioners, hospitals, and other providers of medical  
25 services by clients. In order to ensure patient freedom of  
26 choice, the Illinois Department shall immediately promulgate

1 all rules and take all other necessary actions so that provided  
2 services may be accessed from therapeutically certified  
3 optometrists to the full extent of the Illinois Optometric  
4 Practice Act of 1987 without discriminating between service  
5 providers.

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

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

1 with regulations promulgated by the Illinois Department. The  
2 rules and regulations shall require that proof of the receipt  
3 of prescription drugs, dentures, prosthetic devices and  
4 eyeglasses by eligible persons under this Section accompany  
5 each claim for reimbursement submitted by the dispenser of such  
6 medical services. No such claims for reimbursement shall be  
7 approved for payment by the Illinois Department without such  
8 proof of receipt, unless the Illinois Department shall have put  
9 into effect and shall be operating a system of post-payment  
10 audit and review which shall, on a sampling basis, be deemed  
11 adequate by the Illinois Department to assure that such drugs,  
12 dentures, prosthetic devices and eyeglasses for which payment  
13 is being made are actually being received by eligible  
14 recipients. Within 90 days after September 16, 1984 (the  
15 effective date of Public Act 83-1439), the Illinois Department  
16 shall establish a current list of acquisition costs for all  
17 prosthetic devices and any other items recognized as medical  
18 equipment and supplies reimbursable under this Article and  
19 shall update such list on a quarterly basis, except that the  
20 acquisition costs of all prescription drugs shall be updated no  
21 less frequently than every 30 days as required by Section  
22 5-5.12.

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

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

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

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



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

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

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

21           Prior to enrollment and during the conditional enrollment  
22 period in the medical assistance program, all vendors shall be  
23 subject to enhanced oversight, screening, and review based on  
24 the risk of fraud, waste, and abuse that is posed by the  
25 category of risk of the vendor. The Illinois Department shall  
26 establish the procedures for oversight, screening, and review,

1 which may include, but need not be limited to: criminal and  
2 financial background checks; fingerprinting; license,  
3 certification, and authorization verifications; unscheduled or  
4 unannounced site visits; database checks; prepayment audit  
5 reviews; audits; payment caps; payment suspensions; and other  
6 screening as required by federal or State law.

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

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

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

1 the Illinois Department that the provider enrollment is  
2 complete.

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

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

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

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

21 In the case of long term care facilities, within 45  
22 calendar days of receipt by the facility of required  
23 prescreening information, new admissions with associated  
24 admission documents shall be submitted through the Medical  
25 Electronic Data Interchange (MEDI) or the Recipient  
26 Eligibility Verification (REV) System or shall be submitted

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

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

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

1 corporate information; and death records.

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

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

1 post-adjudicated predictive modeling with an integrated case  
2 management system with link analysis. Such a request for  
3 information shall not be considered as a request for proposal  
4 or as an obligation on the part of the Illinois Department to  
5 take any action or acquire any products or services.

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

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

9           In order to promote environmental responsibility, meet the  
10 needs of recipients and enrollees, and achieve significant cost  
11 savings, the Department, or a managed care organization under  
12 contract with the Department, may provide recipients or managed  
13 care enrollees who have a prescription or Certificate of  
14 Medical Necessity access to refurbished durable medical  
15 equipment under this Section (excluding prosthetic and  
16 orthotic devices as defined in the Orthotics, Prosthetics, and  
17 Pedorthics Practice Act and complex rehabilitation technology  
18 products and associated services) through the State's  
19 assistive technology program's reutilization program, using  
20 staff with the Assistive Technology Professional (ATP)  
21 Certification if the refurbished durable medical equipment:  
22 (i) is available; (ii) is less expensive, including shipping  
23 costs, than new durable medical equipment of the same type;  
24 (iii) is able to withstand at least 3 years of use; (iv) is  
25 cleaned, disinfected, sterilized, and safe in accordance with  
26 federal Food and Drug Administration regulations and guidance

1 governing the reprocessing of medical devices in health care  
2 settings; and (v) equally meets the needs of the recipient or  
3 enrollee. The reutilization program shall confirm that the  
4 recipient or enrollee is not already in receipt of same or  
5 similar equipment from another service provider, and that the  
6 refurbished durable medical equipment equally meets the needs  
7 of the recipient or enrollee. Nothing in this paragraph shall  
8 be construed to limit recipient or enrollee choice to obtain  
9 new durable medical equipment or place any additional prior  
10 authorization conditions on enrollees of managed care  
11 organizations.

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



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

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

23 The Illinois Department shall report annually to the  
24 General Assembly, no later than the second Friday in April of  
25 1979 and each year thereafter, in regard to:

26 (a) actual statistics and trends in utilization of

1 medical services by public aid recipients;

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

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

6 (d) efforts at utilization review and control by the  
7 Illinois Department.

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

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

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

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

22           Notwithstanding any other provision of this Code to the  
23 contrary, on or after July 1, 2015, all FDA approved forms of  
24 medication assisted treatment prescribed for the treatment of  
25 alcohol dependence or treatment of opioid dependence shall be  
26 covered under both fee for service and managed care medical

1 assistance programs for persons who are otherwise eligible for  
2 medical assistance under this Article and shall not be subject  
3 to any (1) utilization control, other than those established  
4 under the American Society of Addiction Medicine patient  
5 placement criteria, (2) prior authorization mandate, or (3)  
6 lifetime restriction limit mandate.

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

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

1 transmitted infections, medical monitoring, assorted labs, and  
2 counseling to reduce the likelihood of HIV infection among  
3 individuals who are not infected with HIV but who are at high  
4 risk of HIV infection.

5 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;  
6 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for  
7 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;  
8 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.  
9 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,  
10 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;  
11 100-538, eff. 1-1-18; revised 10-26-17.)".