HB4184

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB4184

Introduced 1/22/2020, by Rep. Kathleen Willis

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. Provides that, on and after July 1, 2020, targeted dental services that are provided to adults and children under the Medical Assistance Program shall be established and paid at no less than the rates established under the State of Illinois Dental Benefit Schedule and shall include specified dental procedures. Sets forth the reimbursement rates for certain anesthesia services. Effective immediately.

LRB101 16153 KTG 65521 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, provided by an individual licensed to practice
22 dentistry or dental surgery; for purposes of this item (10),
23 "dental services" means diagnostic, preventive, or corrective

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

1 laws of this State. The term "any other type of remedial care"
2 shall include nursing care and nursing home service for persons
3 who rely on treatment by spiritual means alone through prayer
4 for healing.

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

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

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

24 Upon receipt of federal approval of an amendment to the
25 Illinois Title XIX State Plan for this purpose, the Department
26 shall authorize the Chicago Public Schools (CPS) to procure a

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

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

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

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

1 On and after July 1, 2018, the Department of Healthcare and
2 Family Services shall provide dental services to any adult who
3 is otherwise eligible for assistance under the medical
4 assistance program. As used in this paragraph, "dental
5 services" means diagnostic, preventative, restorative, or
6 corrective procedures, including procedures and services for
7 the prevention and treatment of periodontal disease and dental
8 caries disease, provided by an individual who is licensed to
9 practice dentistry or dental surgery or who is under the
10 supervision of a dentist in the practice of his or her
11 profession.

12 On and after July 1, 2018, targeted dental services, as set
13 forth in Exhibit D of the Consent Decree entered by the United
14 States District Court for the Northern District of Illinois,
15 Eastern Division, in the matter of Memisovski v. Maram, Case
16 No. 92 C 1982, that are provided to adults under the medical
17 assistance program shall be established at no less than the
18 rates set forth in the "New Rate" column in Exhibit D of the
19 Consent Decree for targeted dental services that are provided
20 to persons under the age of 18 under the medical assistance
21 program.

22 On and after July 1, 2020, targeted dental services that
23 are provided to adults and children under the Medical
24 Assistance Program shall be established and paid at no less
25 than the rates established under the State of Illinois Dental
26 Benefit Schedule and shall include the following dental

1 procedures: D0120, D0150, D0220, D0230, D0272, D1110, D1120,
2 D1206, D1351, D2140, D2150, D2160, D2161, D2330, D2331, D2332,
3 D2335, D2391, D2392, D2393, D2394, D2751, D2930, D2931, D2950,
4 D5110, D5120, D5211, D5212, D5213, D5214, D7140, D7210, D7220.
5 The following anesthesia related codes shall be reimbursed as
6 follows:

7 (i) D9230 Inhalation of nitrous, $70.00.
8 (ii) D9248 Non-intravenous conscious sedation,
9 $150.00.
10 (iii) D9239 Intravenous moderate sedation, first 15
11 minutes, $181.00.
12 (iv) D9243 Intravenous moderate sedation, each
13 additional 15 minutes, $181.00.
14 (v) D9222 Deep sedation, first 15 minutes, $214.00.
15 (vi) D9223 Deep sedation, each additional 15 minutes,
16 $214.00.

17 Notwithstanding any other provision of this Code and
18 subject to federal approval, the Department may adopt rules to
19 allow a dentist who is volunteering his or her service at no
20 cost to render dental services through an enrolled
21 not-for-profit health clinic without the dentist personally
22 enrolling as a participating provider in the medical assistance
23 program. A not-for-profit health clinic shall include a public
24 health clinic or Federally Qualified Health Center or other
25 enrolled provider, as determined by the Department, through
26 which dental services covered under this Section are performed.

1 The Department shall establish a process for payment of claims
2 for reimbursement for covered dental services rendered under
3 this provision.

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

7 The Department of Healthcare and Family Services must
8 provide coverage and reimbursement for amino acid-based
9 elemental formulas, regardless of delivery method, for the
10 diagnosis and treatment of (i) eosinophilic disorders and (ii)
11 short bowel syndrome when the prescribing physician has issued
12 a written order stating that the amino acid-based elemental
13 formula is medically necessary.

14 The Illinois Department shall authorize the provision of,
15 and shall authorize payment for, screening by low-dose
16 mammography for the presence of occult breast cancer for women
17 35 years of age or older who are eligible for medical
18 assistance under this Article, as follows:

19 (A) A baseline mammogram for women 35 to 39 years of
20 age.

21 (B) An annual mammogram for women 40 years of age or
22 older.

23 (C) A mammogram at the age and intervals considered
24 medically necessary by the woman's health care provider for
25 women under 40 years of age and having a family history of
26 breast cancer, prior personal history of breast cancer,

1 positive genetic testing, or other risk factors.
2 (D) A comprehensive ultrasound screening and MRI of an
3 entire breast or breasts if a mammogram demonstrates
4 heterogeneous or dense breast tissue or when medically
5 necessary as determined by a physician licensed to practice
6 medicine in all of its branches.
7 (E) A screening MRI when medically necessary, as
8 determined by a physician licensed to practice medicine in
9 all of its branches.
10 (F) A diagnostic mammogram when medically necessary,
11 as determined by a physician licensed to practice medicine
12 in all its branches, advanced practice registered nurse, or
13 physician assistant.
14 The Department shall not impose a deductible, coinsurance,
15 copayment, or any other cost-sharing requirement on the
16 coverage provided under this paragraph; except that this
17 sentence does not apply to coverage of diagnostic mammograms to
18 the extent such coverage would disqualify a high-deductible
19 health plan from eligibility for a health savings account
20 pursuant to Section 223 of the Internal Revenue Code (26 U.S.C.
21 223).
22 All screenings shall include a physical breast exam,
23 instruction on self-examination and information regarding the
24 frequency of self-examination and its value as a preventative
25 tool.
26 For purposes of this Section:

1 "Diagnostic mammogram" means a mammogram obtained using
2 diagnostic mammography.
3 "Diagnostic mammography" means a method of screening that
4 is designed to evaluate an abnormality in a breast, including
5 an abnormality seen or suspected on a screening mammogram or a
6 subjective or objective abnormality otherwise detected in the
7 breast.
8 "Low-dose mammography" means the x-ray examination of the
9 breast using equipment dedicated specifically for mammography,
10 including the x-ray tube, filter, compression device, and image
11 receptor, with an average radiation exposure delivery of less
12 than one rad per breast for 2 views of an average size breast.
13 The term also includes digital mammography and includes breast
14 tomosynthesis.
15 "Breast tomosynthesis" means a radiologic procedure that
16 involves the acquisition of projection images over the
17 stationary breast to produce cross-sectional digital
18 three-dimensional images of the breast.
19 If, at any time, the Secretary of the United States
20 Department of Health and Human Services, or its successor
21 agency, promulgates rules or regulations to be published in the
22 Federal Register or publishes a comment in the Federal Register
23 or issues an opinion, guidance, or other action that would
24 require the State, pursuant to any provision of the Patient
25 Protection and Affordable Care Act (Public Law 111-148),
26 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any

successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

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

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

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

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

1 The Department shall convene an expert panel, including
2 representatives of hospitals, free-standing breast cancer
3 treatment centers, breast cancer quality organizations, and
4 doctors, including breast surgeons, reconstructive breast
5 surgeons, oncologists, and primary care providers to establish
6 quality standards for breast cancer treatment.

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

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

23 The Department shall establish a performance goal for
24 primary care providers with respect to their female patients
25 over age 40 receiving an annual mammogram. This performance
26 goal shall be used to provide additional reimbursement in the

form of a quality performance bonus to primary care providers who meet that goal.

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. On or after July 1, 2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within metropolitan Chicago. An evaluation of the pilot program shall be carried out measuring health outcomes and cost of care for those served by the pilot program compared to similarly situated patients who are not served by the pilot program.

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

Any medical or health care provider shall immediately recommend, to any pregnant woman who is being provided prenatal

1 services and is suspected of having a substance use disorder as
2 defined in the Substance Use Disorder Act, referral to a local
3 substance use disorder treatment program licensed by the
4 Department of Human Services or to a licensed hospital which
5 provides substance abuse treatment services. The Department of
6 Healthcare and Family Services shall assure coverage for the
7 cost of treatment of the drug abuse or addiction for pregnant
8 recipients in accordance with the Illinois Medicaid Program in
9 conjunction with the Department of Human Services.

10 All medical providers providing medical assistance to
11 pregnant women under this Code shall receive information from
12 the Department on the availability of services under any
13 program providing case management services for addicted women,
14 including information on appropriate referrals for other
15 social services that may be needed by addicted women in
16 addition to treatment for addiction.

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

25 Neither the Department of Healthcare and Family Services
26 nor the Department of Human Services shall sanction the

1 recipient solely on the basis of her substance abuse.
2 The Illinois Department shall establish such regulations
3 governing the dispensing of health services under this Article
4 as it shall deem appropriate. The Department should seek the
5 advice of formal professional advisory committees appointed by
6 the Director of the Illinois Department for the purpose of
7 providing regular advice on policy and administrative matters,
8 information dissemination and educational activities for
9 medical and health care providers, and consistency in
10 procedures to the Illinois Department.
11 The Illinois Department may develop and contract with
12 Partnerships of medical providers to arrange medical services
13 for persons eligible under Section 5-2 of this Code.
14 Implementation of this Section may be by demonstration projects
15 in certain geographic areas. The Partnership shall be
16 represented by a sponsor organization. The Department, by rule,
17 shall develop qualifications for sponsors of Partnerships.
18 Nothing in this Section shall be construed to require that the
19 sponsor organization be a medical organization.
20 The sponsor must negotiate formal written contracts with
21 medical providers for physician services, inpatient and
22 outpatient hospital care, home health services, treatment for
23 alcoholism and substance abuse, and other services determined
24 necessary by the Illinois Department by rule for delivery by
25 Partnerships. Physician services must include prenatal and
26 obstetrical care. The Illinois Department shall reimburse

1 medical services delivered by Partnership providers to clients
2 in target areas according to provisions of this Article and the
3 Illinois Health Finance Reform Act, except that:
4 (1) Physicians participating in a Partnership and
5 providing certain services, which shall be determined by
6 the Illinois Department, to persons in areas covered by the
7 Partnership may receive an additional surcharge for such
8 services.
9 (2) The Department may elect to consider and negotiate
10 financial incentives to encourage the development of
11 Partnerships and the efficient delivery of medical care.
12 (3) Persons receiving medical services through
13 Partnerships may receive medical and case management
14 services above the level usually offered through the
15 medical assistance program.
16 Medical providers shall be required to meet certain
17 qualifications to participate in Partnerships to ensure the
18 delivery of high quality medical services. These
19 qualifications shall be determined by rule of the Illinois
20 Department and may be higher than qualifications for
21 participation in the medical assistance program. Partnership
22 sponsors may prescribe reasonable additional qualifications
23 for participation by medical providers, only with the prior
24 written approval of the Illinois Department.
25 Nothing in this Section shall limit the free choice of
26 practitioners, hospitals, and other providers of medical

1 services by clients. In order to ensure patient freedom of
2 choice, the Illinois Department shall immediately promulgate
3 all rules and take all other necessary actions so that provided
4 services may be accessed from therapeutically certified
5 optometrists to the full extent of the Illinois Optometric
6 Practice Act of 1987 without discriminating between service
7 providers.

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

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

1 details and receipt of the health care provided to persons
2 eligible for medical assistance under this Code, in accordance
3 with regulations promulgated by the Illinois Department. The
4 rules and regulations shall require that proof of the receipt
5 of prescription drugs, dentures, prosthetic devices and
6 eyeglasses by eligible persons under this Section accompany
7 each claim for reimbursement submitted by the dispenser of such
8 medical services. No such claims for reimbursement shall be
9 approved for payment by the Illinois Department without such
10 proof of receipt, unless the Illinois Department shall have put
11 into effect and shall be operating a system of post-payment
12 audit and review which shall, on a sampling basis, be deemed
13 adequate by the Illinois Department to assure that such drugs,
14 dentures, prosthetic devices and eyeglasses for which payment
15 is being made are actually being received by eligible
16 recipients. Within 90 days after September 16, 1984 (the
17 effective date of Public Act 83-1439), the Illinois Department
18 shall establish a current list of acquisition costs for all
19 prosthetic devices and any other items recognized as medical
20 equipment and supplies reimbursable under this Article and
21 shall update such list on a quarterly basis, except that the
22 acquisition costs of all prescription drugs shall be updated no
23 less frequently than every 30 days as required by Section
24 5-5.12.

25 Notwithstanding any other law to the contrary, the Illinois
26 Department shall, within 365 days after July 22, 2013 (the

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

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

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

1 institutions or other legal entities providing any form of
2 health care services in this State under this Article.
3 The Illinois Department may require that all dispensers of
4 medical services desiring to participate in the medical
5 assistance program established under this Article disclose,
6 under such terms and conditions as the Illinois Department may
7 by rule establish, all inquiries from clients and attorneys
8 regarding medical bills paid by the Illinois Department, which
9 inquiries could indicate potential existence of claims or liens
10 for the Illinois Department.
11 Enrollment of a vendor shall be subject to a provisional
12 period and shall be conditional for one year. During the period
13 of conditional enrollment, the Department may terminate the
14 vendor's eligibility to participate in, or may disenroll the
15 vendor from, the medical assistance program without cause.
16 Unless otherwise specified, such termination of eligibility or
17 disenrollment is not subject to the Department's hearing
18 process. However, a disenrolled vendor may reapply without
19 penalty.
20 The Department has the discretion to limit the conditional
21 enrollment period for vendors based upon category of risk of
22 the vendor.
23 Prior to enrollment and during the conditional enrollment
24 period in the medical assistance program, all vendors shall be
25 subject to enhanced oversight, screening, and review based on
26 the risk of fraud, waste, and abuse that is posed by the

1 category of risk of the vendor. The Illinois Department shall
2 establish the procedures for oversight, screening, and review,
3 which may include, but need not be limited to: criminal and
4 financial background checks; fingerprinting; license,
5 certification, and authorization verifications; unscheduled or
6 unannounced site visits; database checks; prepayment audit
7 reviews; audits; payment caps; payment suspensions; and other
8 screening as required by federal or State law.

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

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

26 (1) In the case of a provider whose enrollment is in

1 process by the Illinois Department, the 180-day period
2 shall not begin until the date on the written notice from
3 the Illinois Department that the provider enrollment is
4 complete.

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

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

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

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

23 In the case of long term care facilities, within 45
24 calendar days of receipt by the facility of required
25 prescreening information, new admissions with associated
26 admission documents shall be submitted through the Medical

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

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

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

1 National Practitioner Data Bank (NPDB); program and agency
2 exclusions; taxpayer identification numbers; tax delinquency;
3 corporate information; and death records.
4 The Illinois Department shall enter into agreements with
5 State agencies and departments, and is authorized to enter into
6 agreements with federal agencies and departments, under which
7 such agencies and departments shall share data necessary for
8 medical assistance program integrity functions and oversight.
9 The Illinois Department shall develop, in cooperation with
10 other State departments and agencies, and in compliance with
11 applicable federal laws and regulations, appropriate and
12 effective methods to share such data. At a minimum, and to the
13 extent necessary to provide data sharing, the Illinois
14 Department shall enter into agreements with State agencies and
15 departments, and is authorized to enter into agreements with
16 federal agencies and departments, including, but not limited
17 to: the Secretary of State; the Department of Revenue; the
18 Department of Public Health; the Department of Human Services;
19 and the Department of Financial and Professional Regulation.
20 Beginning in fiscal year 2013, the Illinois Department
21 shall set forth a request for information to identify the
22 benefits of a pre-payment, post-adjudication, and post-edit
23 claims system with the goals of streamlining claims processing
24 and provider reimbursement, reducing the number of pending or
25 rejected claims, and helping to ensure a more transparent
26 adjudication process through the utilization of: (i) provider

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

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

determine the wholesale price by methods other than actual acquisition costs.

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

In order to promote environmental responsibility, meet the needs of recipients and enrollees, and achieve significant cost savings, the Department, or a managed care organization under contract with the Department, may provide recipients or managed care enrollees who have a prescription or Certificate of Medical Necessity access to refurbished durable medical equipment under this Section (excluding prosthetic and orthotic devices as defined in the Orthotics, Prosthetics, and Pedorthics Practice Act and complex rehabilitation technology products and associated services) through the State's assistive technology program's reutilization program, using staff with the Assistive Technology Professional (ATP) Certification if the refurbished durable medical equipment: (i) is available; (ii) is less expensive, including shipping costs, than new durable medical equipment of the same type; (iii) is able to withstand at least 3 years of use; (iv) is

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

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

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

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

25 The Illinois Department shall report annually to the
26 General Assembly, no later than the second Friday in April of

1979 and each year thereafter, in regard to:

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

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

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

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

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act, and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

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

On and after July 1, 2012, the Department shall reduce any 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,
5 cost-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

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

A federally qualified health center, as defined in Section 1905(l)(2)(B) of the federal Social Security Act, shall be reimbursed by the Department in accordance with the federally qualified health center's encounter rate for services provided to medical assistance recipients that are performed by a dental hygienist, as defined under the Illinois Dental Practice Act, working under the general supervision of a dentist and employed by a federally qualified health center.

(Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; revised 9-18-19.)

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