

**SB1333**



**101ST GENERAL ASSEMBLY**

**State of Illinois**

**2019 and 2020**

**SB1333**

Introduced 2/7/2019, by Sen. Chapin Rose

**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 continuous glucose monitors shall be covered under the medical assistance program for children with diabetes who are under the age of 19 and otherwise eligible for medical assistance under the Article.

LRB101 06808 KTG 51837 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           Notwithstanding any other provision of this Code and  
23 subject to federal approval, the Department may adopt rules to  
24 allow a dentist who is volunteering his or her service at no  
25 cost to render dental services through an enrolled  
26 not-for-profit health clinic without the dentist personally

1 enrolling as a participating provider in the medical assistance  
2 program. A not-for-profit health clinic shall include a public  
3 health clinic or Federally Qualified Health Center or other  
4 enrolled provider, as determined by the Department, through  
5 which dental services covered under this Section are performed.  
6 The Department shall establish a process for payment of claims  
7 for reimbursement for covered dental services rendered under  
8 this provision.

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

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

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

24 (A) A baseline mammogram for women 35 to 39 years of  
25 age.

26 (B) An annual mammogram for women 40 years of age or

1           older.

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

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

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

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



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

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

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

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

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

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

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

24           The Department shall establish a methodology to remind  
25 women who are age-appropriate for screening mammography, but  
26 who have not received a mammogram within the previous 18

1 months, of the importance and benefit of screening mammography.  
2 The Department shall work with experts in breast cancer  
3 outreach and patient navigation to optimize these reminders and  
4 shall establish a methodology for evaluating their  
5 effectiveness and modifying the methodology based on the  
6 evaluation.

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

13 The Department shall devise a means of case-managing or  
14 patient navigation for beneficiaries diagnosed with breast  
15 cancer. This program shall initially operate as a pilot program  
16 in areas of the State with the highest incidence of mortality  
17 related to breast cancer. At least one pilot program site shall  
18 be in the metropolitan Chicago area and at least one site shall  
19 be outside the metropolitan Chicago area. On or after July 1,  
20 2016, the pilot program shall be expanded to include one site  
21 in western Illinois, one site in southern Illinois, one site in  
22 central Illinois, and 4 sites within metropolitan Chicago. An  
23 evaluation of the pilot program shall be carried out measuring  
24 health outcomes and cost of care for those served by the pilot  
25 program compared to similarly situated patients who are not  
26 served by the pilot program.

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

9           Any medical or health care provider shall immediately  
10 recommend, to any pregnant woman who is being provided prenatal  
11 services and is suspected of having a substance use disorder as  
12 defined in the Substance Use Disorder Act, referral to a local  
13 substance use disorder treatment program licensed by the  
14 Department of Human Services or to a licensed hospital which  
15 provides substance abuse treatment services. The Department of  
16 Healthcare and Family Services shall assure coverage for the  
17 cost of treatment of the drug abuse or addiction for pregnant  
18 recipients in accordance with the Illinois Medicaid Program in  
19 conjunction with the Department of Human Services.

20           All medical providers providing medical assistance to  
21 pregnant women under this Code shall receive information from  
22 the Department on the availability of services under any  
23 program providing case management services for addicted women,  
24 including information on appropriate referrals for other  
25 social services that may be needed by addicted women in  
26 addition to treatment for addiction.

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

9           Neither the Department of Healthcare and Family Services  
10 nor the Department of Human Services shall sanction the  
11 recipient solely on the basis of her substance abuse.

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

21           The Illinois Department may develop and contract with  
22 Partnerships of medical providers to arrange medical services  
23 for persons eligible under Section 5-2 of this Code.  
24 Implementation of this Section may be by demonstration projects  
25 in certain geographic areas. The Partnership shall be  
26 represented by a sponsor organization. The Department, by rule,

1 shall develop qualifications for sponsors of Partnerships.  
2 Nothing in this Section shall be construed to require that the  
3 sponsor organization be a medical organization.

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

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

19 (2) The Department may elect to consider and negotiate  
20 financial incentives to encourage the development of  
21 Partnerships and the efficient delivery of medical care.

22 (3) Persons receiving medical services through  
23 Partnerships may receive medical and case management  
24 services above the level usually offered through the  
25 medical assistance program.

26 Medical providers shall be required to meet certain

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

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

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

21 The Illinois Department shall require health care  
22 providers to maintain records that document the medical care  
23 and services provided to recipients of Medical Assistance under  
24 this Article. Such records must be retained for a period of not  
25 less than 6 years from the date of service or as provided by  
26 applicable State law, whichever period is longer, except that

1 if an audit is initiated within the required retention period  
2 then the records must be retained until the audit is completed  
3 and every exception is resolved. The Illinois Department shall  
4 require health care providers to make available, when  
5 authorized by the patient, in writing, the medical records in a  
6 timely fashion to other health care providers who are treating  
7 or serving persons eligible for Medical Assistance under this  
8 Article. All dispensers of medical services shall be required  
9 to maintain and retain business and professional records  
10 sufficient to fully and accurately document the nature, scope,  
11 details and receipt of the health care provided to persons  
12 eligible for medical assistance under this Code, in accordance  
13 with regulations promulgated by the Illinois Department. The  
14 rules and regulations shall require that proof of the receipt  
15 of prescription drugs, dentures, prosthetic devices and  
16 eyeglasses by eligible persons under this Section accompany  
17 each claim for reimbursement submitted by the dispenser of such  
18 medical services. No such claims for reimbursement shall be  
19 approved for payment by the Illinois Department without such  
20 proof of receipt, unless the Illinois Department shall have put  
21 into effect and shall be operating a system of post-payment  
22 audit and review which shall, on a sampling basis, be deemed  
23 adequate by the Illinois Department to assure that such drugs,  
24 dentures, prosthetic devices and eyeglasses for which payment  
25 is being made are actually being received by eligible  
26 recipients. Within 90 days after September 16, 1984 (the



1 effective date of Public Act 83-1439), the Illinois Department  
2 shall establish a current list of acquisition costs for all  
3 prosthetic devices and any other items recognized as medical  
4 equipment and supplies reimbursable under this Article and  
5 shall update such list on a quarterly basis, except that the  
6 acquisition costs of all prescription drugs shall be updated no  
7 less frequently than every 30 days as required by Section  
8 5-5.12.

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

20 Notwithstanding any other law to the contrary, the Illinois  
21 Department shall, within 365 days after August 15, 2014 (the  
22 effective date of Public Act 98-963), establish procedures to  
23 permit ID/DD facilities licensed under the ID/DD Community Care  
24 Act and MC/DD facilities licensed under the MC/DD Act to submit  
25 monthly billing claims for reimbursement purposes. Following  
26 development of these procedures, the Department shall have an

1 additional 365 days to test the viability of the new system and  
2 to ensure that any necessary operational or structural changes  
3 to its information technology platforms are implemented.

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

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

21 Enrollment of a vendor shall be subject to a provisional  
22 period and shall be conditional for one year. During the period  
23 of conditional enrollment, the Department may terminate the  
24 vendor's eligibility to participate in, or may disenroll the  
25 vendor from, the medical assistance program without cause.  
26 Unless otherwise specified, such termination of eligibility or

1 disenrollment is not subject to the Department's hearing  
2 process. However, a disenrolled vendor may reapply without  
3 penalty.

4 The Department has the discretion to limit the conditional  
5 enrollment period for vendors based upon category of risk of  
6 the vendor.

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

19 The Department shall define or specify the following: (i)  
20 by provider notice, the "category of risk of the vendor" for  
21 each type of vendor, which shall take into account the level of  
22 screening applicable to a particular category of vendor under  
23 federal law and regulations; (ii) by rule or provider notice,  
24 the maximum length of the conditional enrollment period for  
25 each category of risk of the vendor; and (iii) by rule, the  
26 hearing rights, if any, afforded to a vendor in each category

1 of risk of the vendor that is terminated or disenrolled during  
2 the conditional enrollment period.

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

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

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

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

22 (4) In the case of a provider operated by a unit of  
23 local government with a population exceeding 3,000,000  
24 when local government funds finance federal participation  
25 for claims payments.

26 For claims for services rendered during a period for which

1 a recipient received retroactive eligibility, claims must be  
2 filed within 180 days after the Department determines the  
3 applicant is eligible. For claims for which the Illinois  
4 Department is not the primary payer, claims must be submitted  
5 to the Illinois Department within 180 days after the final  
6 adjudication by the primary payer.

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

22 Claims that are not submitted and received in compliance  
23 with the foregoing requirements shall not be eligible for  
24 payment under the medical assistance program, and the State  
25 shall have no liability for payment of those claims.

26 To the extent consistent with applicable information and

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

14 The Illinois Department shall enter into agreements with  
15 State agencies and departments, and is authorized to enter into  
16 agreements with federal agencies and departments, under which  
17 such agencies and departments shall share data necessary for  
18 medical assistance program integrity functions and oversight.  
19 The Illinois Department shall develop, in cooperation with  
20 other State departments and agencies, and in compliance with  
21 applicable federal laws and regulations, appropriate and  
22 effective methods to share such data. At a minimum, and to the  
23 extent necessary to provide data sharing, the Illinois  
24 Department shall enter into agreements with State agencies and  
25 departments, and is authorized to enter into agreements with  
26 federal agencies and departments, including but not limited to:

1 the Secretary of State; the Department of Revenue; the  
2 Department of Public Health; the Department of Human Services;  
3 and the Department of Financial and Professional Regulation.

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

18 The Illinois Department shall establish policies,  
19 procedures, standards and criteria by rule for the acquisition,  
20 repair and replacement of orthotic and prosthetic devices and  
21 durable medical equipment. Such rules shall provide, but not be  
22 limited to, the following services: (1) immediate repair or  
23 replacement of such devices by recipients; and (2) rental,  
24 lease, purchase or lease-purchase of durable medical equipment  
25 in a cost-effective manner, taking into consideration the  
26 recipient's medical prognosis, the extent of the recipient's

1 needs, and the requirements and costs for maintaining such  
2 equipment. Subject to prior approval, such rules shall enable a  
3 recipient to temporarily acquire and use alternative or  
4 substitute devices or equipment pending repairs or  
5 replacements of any device or equipment previously authorized  
6 for such recipient by the Department. Notwithstanding any  
7 provision of Section 5-5f to the contrary, the Department may,  
8 by rule, exempt certain replacement wheelchair parts from prior  
9 approval and, for wheelchairs, wheelchair parts, wheelchair  
10 accessories, and related seating and positioning items,  
11 determine the wholesale price by methods other than actual  
12 acquisition costs.

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

21 In order to promote environmental responsibility, meet the  
22 needs of recipients and enrollees, and achieve significant cost  
23 savings, the Department, or a managed care organization under  
24 contract with the Department, may provide recipients or managed  
25 care enrollees who have a prescription or Certificate of  
26 Medical Necessity access to refurbished durable medical



1 equipment under this Section (excluding prosthetic and  
2 orthotic devices as defined in the Orthotics, Prosthetics, and  
3 Pedorthics Practice Act and complex rehabilitation technology  
4 products and associated services) through the State's  
5 assistive technology program's reutilization program, using  
6 staff with the Assistive Technology Professional (ATP)  
7 Certification if the refurbished durable medical equipment:  
8 (i) is available; (ii) is less expensive, including shipping  
9 costs, than new durable medical equipment of the same type;  
10 (iii) is able to withstand at least 3 years of use; (iv) is  
11 cleaned, disinfected, sterilized, and safe in accordance with  
12 federal Food and Drug Administration regulations and guidance  
13 governing the reprocessing of medical devices in health care  
14 settings; and (v) equally meets the needs of the recipient or  
15 enrollee. The reutilization program shall confirm that the  
16 recipient or enrollee is not already in receipt of same or  
17 similar equipment from another service provider, and that the  
18 refurbished durable medical equipment equally meets the needs  
19 of the recipient or enrollee. Nothing in this paragraph shall  
20 be construed to limit recipient or enrollee choice to obtain  
21 new durable medical equipment or place any additional prior  
22 authorization conditions on enrollees of managed care  
23 organizations.

24 The Department shall execute, relative to the nursing home  
25 prescreening project, written inter-agency agreements with the  
26 Department of Human Services and the Department on Aging, to

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

1 circumstances where federal approval has been granted.

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

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

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

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

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

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

20 The period covered by each report shall be the 3 years  
21 ending on the June 30 prior to the report. The report shall  
22 include suggested legislation for consideration by the General  
23 Assembly. The requirement for reporting to the General Assembly  
24 shall be satisfied by filing copies of the report as required  
25 by Section 3.1 of the General Assembly Organization Act, and  
26 filing such additional copies with the State Government Report

1 Distribution Center for the General Assembly as is required  
2 under paragraph (t) of Section 7 of the State Library Act.

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

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

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

1 Department to perform kidney transplantation and the services  
2 under this Section shall be limited to services associated with  
3 kidney transplantation.

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

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

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

13           A federally qualified health center, as defined in Section  
14 1905(1)(2)(B) of the federal Social Security Act, shall be  
15 reimbursed by the Department in accordance with the federally  
16 qualified health center's encounter rate for services provided  
17 to medical assistance recipients that are performed by a dental  
18 hygienist, as defined under the Illinois Dental Practice Act,  
19 working under the general supervision of a dentist and employed  
20 by a federally qualified health center.

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

1       Notwithstanding any other provision of this Code,  
2       continuous glucose monitors shall be covered under the medical  
3       assistance program for children with diabetes who are under the  
4       age of 19 and otherwise eligible for medical assistance under  
5       this Article.

6       (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;  
7       99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for  
8       the effective date of P.A. 99-407); 99-433, eff. 8-21-15;  
9       99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.  
10      7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,  
11      eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;  
12      100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff.  
13      1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18;  
14      100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff.  
15      12-10-18.)