



Rep. David R. Leitch

Filed: 4/20/2015

09900HB1876ham001

LRB099 06677 KTG 34378 a

1 AMENDMENT TO HOUSE BILL 1876

2 AMENDMENT NO. _____. Amend House Bill 1876 by replacing
3 everything after the enacting clause with the following:

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

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

7 Sec. 5-5. Medical services. The Illinois Department, by
8 rule, shall determine the quantity and quality of and the rate
9 of reimbursement for the medical assistance for which payment
10 will be authorized, and the medical services to be provided,
11 which may include all or part of the following: (1) inpatient
12 hospital services; (2) outpatient hospital services; (3) other
13 laboratory and X-ray services; (4) skilled nursing home
14 services; (5) physicians' services whether furnished in the
15 office, the patient's home, a hospital, a skilled nursing home,
16 or elsewhere; (6) medical care, or any other type of remedial

1 care furnished by licensed practitioners; (7) home health care
2 services; (8) private duty nursing service; (9) clinic
3 services; (10) dental services, including prevention and
4 treatment of periodontal disease and dental caries disease for
5 pregnant women, provided by an individual licensed to practice
6 dentistry or dental surgery; for purposes of this item (10),
7 "dental services" means diagnostic, preventive, or corrective
8 procedures provided by or under the supervision of a dentist in
9 the practice of his or her profession; (11) physical therapy
10 and related services; (12) prescribed drugs, dentures, and
11 prosthetic devices; and eyeglasses prescribed by a physician
12 skilled in the diseases of the eye, or by an optometrist,
13 whichever the person may select; (13) other diagnostic,
14 screening, preventive, and rehabilitative services, including
15 to ensure that the individual's need for intervention or
16 treatment of mental disorders or substance use disorders or
17 co-occurring mental health and substance use disorders is
18 determined using a uniform screening, assessment, and
19 evaluation process inclusive of criteria, for children and
20 adults; for purposes of this item (13), a uniform screening,
21 assessment, and evaluation process refers to a process that
22 includes an appropriate evaluation and, as warranted, a
23 referral; "uniform" does not mean the use of a singular
24 instrument, tool, or process that all must utilize; (14)
25 transportation and such other expenses as may be necessary;
26 (15) medical treatment of sexual assault survivors, as defined

1 in Section 1a of the Sexual Assault Survivors Emergency
2 Treatment Act, for injuries sustained as a result of the sexual
3 assault, including examinations and laboratory tests to
4 discover evidence which may be used in criminal proceedings
5 arising from the sexual assault; (16) the diagnosis and
6 treatment of sickle cell anemia; and (17) any other medical
7 care, and any other type of remedial care recognized under the
8 laws of this State, but not including abortions, or induced
9 miscarriages or premature births, unless, in the opinion of a
10 physician, such procedures are necessary for the preservation
11 of the life of the woman seeking such treatment, or except an
12 induced premature birth intended to produce a live viable child
13 and such procedure is necessary for the health of the mother or
14 her unborn child. The Illinois Department, by rule, shall
15 prohibit any physician from providing medical assistance to
16 anyone eligible therefor under this Code where such physician
17 has been found guilty of performing an abortion procedure in a
18 wilful and wanton manner upon a woman who was not pregnant at
19 the time such abortion procedure was performed. The term "any
20 other type of remedial care" shall include nursing care and
21 nursing home service for persons who rely on treatment by
22 spiritual means alone through prayer for healing.

23 Notwithstanding any other provision of this Section, a
24 comprehensive tobacco use cessation program that includes
25 purchasing prescription drugs or prescription medical devices
26 approved by the Food and Drug Administration shall be covered

1 under the medical assistance program under this Article for
2 persons who are otherwise eligible for assistance under this
3 Article.

4 Notwithstanding any other provision of this Code, the
5 Illinois Department may not require, as a condition of payment
6 for any laboratory test authorized under this Article, that a
7 physician's handwritten signature appear on the laboratory
8 test order form. The Illinois Department may, however, impose
9 other appropriate requirements regarding laboratory test order
10 documentation.

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

1 payment and shall be reimbursed at the Department's or the
2 MCE's established rates or rate methodologies for eyeglasses.

3 On and after July 1, 2012, the Department of Healthcare and
4 Family Services may provide the following services to persons
5 eligible for assistance under this Article who are
6 participating in education, training or employment programs
7 operated by the Department of Human Services as successor to
8 the Department of Public Aid:

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

11 (2) eyeglasses prescribed by a physician skilled in the
12 diseases of the eye, or by an optometrist, whichever the
13 person may select.

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

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

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

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

16 (A) A baseline mammogram for women 35 to 39 years of
17 age.

18 (B) An annual mammogram for women 40 years of age or
19 older.

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

25 (D) A comprehensive ultrasound screening of an entire
26 breast or breasts if a mammogram demonstrates

1 heterogeneous or dense breast tissue, when medically
2 necessary as determined by a physician licensed to practice
3 medicine in all of its branches.

4 All screenings shall include a physical breast exam,
5 instruction on self-examination and information regarding the
6 frequency of self-examination and its value as a preventative
7 tool. For purposes of this Section, "low-dose mammography"
8 means the x-ray examination of the breast using equipment
9 dedicated specifically for mammography, including the x-ray
10 tube, filter, compression device, and image receptor, with an
11 average radiation exposure delivery of less than one rad per
12 breast for 2 views of an average size breast. The term also
13 includes digital mammography.

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

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

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

1 hospital-based mammography facilities.

2 The Department shall establish a methodology to remind
3 women who are age-appropriate for screening mammography, but
4 who have not received a mammogram within the previous 18
5 months, of the importance and benefit of screening mammography.

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

12 The Department shall devise a means of case-managing or
13 patient navigation for beneficiaries diagnosed with breast
14 cancer. This program shall initially operate as a pilot program
15 in areas of the State with the highest incidence of mortality
16 related to breast cancer. At least one pilot program site shall
17 be in the metropolitan Chicago area and at least one site shall
18 be outside the metropolitan Chicago area. An evaluation of the
19 pilot program shall be carried out measuring health outcomes
20 and cost of care for those served by the pilot program compared
21 to similarly situated patients who are not served by the pilot
22 program.

23 Any medical or health care provider shall immediately
24 recommend, to any pregnant woman who is being provided prenatal
25 services and is suspected of drug abuse or is addicted as
26 defined in the Alcoholism and Other Drug Abuse and Dependency

1 Act, referral to a local substance abuse treatment provider
2 licensed by the Department of Human Services or to a licensed
3 hospital which provides substance abuse treatment services.
4 The Department of Healthcare and Family Services shall assure
5 coverage for the cost of treatment of the drug abuse or
6 addiction for pregnant recipients in accordance with the
7 Illinois Medicaid Program in conjunction with the Department of
8 Human Services.

9 All medical providers providing medical assistance to
10 pregnant women under this Code shall receive information from
11 the Department on the availability of services under the Drug
12 Free Families with a Future or any comparable program providing
13 case management services for addicted women, including
14 information on appropriate referrals for other social services
15 that may be needed by addicted women in addition to treatment
16 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 the effective date of this
17 amendatory Act of 1984, the Illinois Department shall establish
18 a current list of acquisition costs for all prosthetic devices
19 and any other items recognized as medical equipment and
20 supplies reimbursable under this Article and shall update such
21 list on a quarterly basis, except that the acquisition costs of
22 all prescription drugs shall be updated no less frequently than
23 every 30 days as required by Section 5-5.12.

24 The rules and regulations of the Illinois Department shall
25 require that a written statement including the required opinion
26 of a physician shall accompany any claim for reimbursement for

1 abortions, or induced miscarriages or premature births. This
2 statement shall indicate what procedures were used in providing
3 such medical services.

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

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

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

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

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

1 The Department has the discretion to limit the conditional
2 enrollment period for vendors based upon category of risk of
3 the vendor.

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

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

26 To be eligible for payment consideration, a vendor's

1 payment claim or bill, either as an initial claim or as a
2 resubmitted claim following prior rejection, must be received
3 by the Illinois Department, or its fiscal intermediary, no
4 later than 180 days after the latest date on the claim on which
5 medical goods or services were provided, with the following
6 exceptions:

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

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

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

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

23 For claims for services rendered during a period for which
24 a recipient received retroactive eligibility, claims must be
25 filed within 180 days after the Department determines the
26 applicant is eligible. For claims for which the Illinois

1 Department is not the primary payer, claims must be submitted
2 to the Illinois Department within 180 days after the final
3 adjudication by the primary payer.

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

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

25 To the extent consistent with applicable information and
26 privacy, security, and disclosure laws, State and federal

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

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

1 Department of Public Health; the Department of Human Services;
2 and the Department of Financial and Professional Regulation.

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

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

1 equipment. Subject to prior approval, such rules shall enable a
2 recipient to temporarily acquire and use alternative or
3 substitute devices or equipment pending repairs or
4 replacements of any device or equipment previously authorized
5 for such recipient by the Department.

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

1 admission date who are seeking or receiving services from the
2 long term care provider. In order to select the minimum level
3 of care eligibility criteria, the Governor shall establish a
4 workgroup that includes affected agency representatives and
5 stakeholders representing the institutional and home and
6 community-based long term care interests. This Section shall
7 not restrict the Department from implementing lower level of
8 care eligibility criteria for community-based services in
9 circumstances where federal approval has been granted.

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

17 The Illinois Department shall report annually to the
18 General Assembly, no later than the second Friday in April of
19 1979 and each year thereafter, in regard to:

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

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

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

26 (d) efforts at utilization review and control by the

1 Illinois Department.

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

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

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

26 Because kidney transplantation can be an appropriate, cost

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

16 (Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689,
17 eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section
18 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff.
19 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651,
20 eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14;
21 revised 10-2-14.)

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