HB2707

LRB09905615KTG25652b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB2707

by Rep. Norine Hammond

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5 from Ch. 23, par. 5-5
305 ILCS 5/12-4.49 new

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to provide medical assistance coverage for diabetes education provided by a certified diabetes education provider for children with Type 1 diabetes who are under the age of 18. Defines "certified diabetes education provider" to mean a professional who has undergone training and certification under conditions approved by the American Association of Diabetes Educators or a successor association of professionals. Defines "Type 1 diabetes" to have the same meaning ascribed to it by the American Diabetes Association or any successor association. Requires the Department to establish a 2-year countywide Medicaid Pilot Program for Diabetes Self-Management Training that covers consultation sessions on blood glucose monitoring, dietary restrictions and options, lifestyle modification, family and community support roles, early appropriate insulin or other medication initiation and administration, and awareness of specific disease-related conditions including hypoglycemia. Contains provisions concerning a reimbursement formula; required competencies for diabetes educators; education standards for diabetes educators; work experience; continuing education; and reporting requirements. Effective January 1, 2016.

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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 and by adding Section 12-4.49 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, but not including abortions, or induced
2 miscarriages or premature births, unless, in the opinion of a
3 physician, such procedures are necessary for the preservation
4 of the life of the woman seeking such treatment, or except an
5 induced premature birth intended to produce a live viable child
6 and such procedure is necessary for the health of the mother or
7 her unborn child. The Illinois Department, by rule, shall
8 prohibit any physician from providing medical assistance to
9 anyone eligible therefor under this Code where such physician
10 has been found guilty of performing an abortion procedure in a
11 wilful and wanton manner upon a woman who was not pregnant at
12 the time such abortion procedure was performed. The term "any
13 other type of remedial care" shall include nursing care and
14 nursing home service for persons who rely on treatment by
15 spiritual means alone through prayer for healing.

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

23 Notwithstanding any other provision of this Code, the
24 Illinois Department may not require, as a condition of payment
25 for any laboratory test authorized under this Article, that a
26 physician's handwritten signature appear on the laboratory

1 test order form. The Illinois Department may, however, impose
2 other appropriate requirements regarding laboratory test order
3 documentation.

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

22 Notwithstanding any other provision of this Code, the
23 Department shall provide medical assistance coverage for
24 diabetes education provided by a certified diabetes education
25 provider for children with Type 1 diabetes who are under the
26 age of 18. For purposes of this paragraph:

1 "Certified diabetes education provider" means a
2 professional who has undergone training and certification
3 under conditions approved by the American Association of
4 Diabetes Educators or a successor association of
5 professionals.
6 "Type 1 diabetes" has the same meaning ascribed to it
7 by the American Diabetes Association or any successor
8 association.
9 On and after July 1, 2012, the Department of Healthcare and
10 Family Services may provide the following services to persons
11 eligible for assistance under this Article who are
12 participating in education, training or employment programs
13 operated by the Department of Human Services as successor to
14 the Department of Public Aid:
15 (1) dental services provided by or under the
16 supervision of a dentist; and
17 (2) eyeglasses prescribed by a physician skilled in the
18 diseases of the eye, or by an optometrist, whichever the
19 person may select.
20 Notwithstanding any other provision of this Code and
21 subject to federal approval, the Department may adopt rules to
22 allow a dentist who is volunteering his or her service at no
23 cost to render dental services through an enrolled
24 not-for-profit health clinic without the dentist personally
25 enrolling as a participating provider in the medical assistance
26 program. A not-for-profit health clinic shall include a public

1 health clinic or Federally Qualified Health Center or other
2 enrolled provider, as determined by the Department, through
3 which dental services covered under this Section are performed.
4 The Department shall establish a process for payment of claims
5 for reimbursement for covered dental services rendered under
6 this provision.

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

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

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

22 (A) A baseline mammogram for women 35 to 39 years of
23 age.

24 (B) An annual mammogram for women 40 years of age or
25 older.

26 (C) A mammogram at the age and intervals considered

1 medically necessary by the woman's health care provider for
2 women under 40 years of age and having a family history of
3 breast cancer, prior personal history of breast cancer,
4 positive genetic testing, or other risk factors.
5 (D) A comprehensive ultrasound screening of an entire
6 breast or breasts if a mammogram demonstrates
7 heterogeneous or dense breast tissue, when medically
8 necessary as determined by a physician licensed to practice
9 medicine in all of its branches.
10 All screenings shall include a physical breast exam,
11 instruction on self-examination and information regarding the
12 frequency of self-examination and its value as a preventative
13 tool. For purposes of this Section, "low-dose mammography"
14 means the x-ray examination of the breast using equipment
15 dedicated specifically for mammography, including the x-ray
16 tube, filter, compression device, and image receptor, with an
17 average radiation exposure delivery of less than one rad per
18 breast for 2 views of an average size breast. The term also
19 includes digital mammography.
20 On and after January 1, 2012, providers participating in a
21 quality improvement program approved by the Department shall be
22 reimbursed for screening and diagnostic mammography at the same
23 rate as the Medicare program's rates, including the increased
24 reimbursement for digital mammography.
25 The Department shall convene an expert panel including
26 representatives of hospitals, free-standing mammography

1 facilities, and doctors, including radiologists, to establish
2 quality standards.
3 Subject to federal approval, the Department shall
4 establish a rate methodology for mammography at federally
5 qualified health centers and other encounter-rate clinics.
6 These clinics or centers may also collaborate with other
7 hospital-based mammography facilities.
8 The Department shall establish a methodology to remind
9 women who are age-appropriate for screening mammography, but
10 who have not received a mammogram within the previous 18
11 months, of the importance and benefit of screening mammography.
12 The Department shall establish a performance goal for
13 primary care providers with respect to their female patients
14 over age 40 receiving an annual mammogram. This performance
15 goal shall be used to provide additional reimbursement in the
16 form of a quality performance bonus to primary care providers
17 who meet that goal.
18 The Department shall devise a means of case-managing or
19 patient navigation for beneficiaries diagnosed with breast
20 cancer. This program shall initially operate as a pilot program
21 in areas of the State with the highest incidence of mortality
22 related to breast cancer. At least one pilot program site shall
23 be in the metropolitan Chicago area and at least one site shall
24 be outside the metropolitan Chicago area. An evaluation of the
25 pilot program shall be carried out measuring health outcomes
26 and cost of care for those served by the pilot program compared

1 to similarly situated patients who are not served by the pilot
2 program.
3 Any medical or health care provider shall immediately
4 recommend, to any pregnant woman who is being provided prenatal
5 services and is suspected of drug abuse or is addicted as
6 defined in the Alcoholism and Other Drug Abuse and Dependency
7 Act, referral to a local substance abuse treatment provider
8 licensed by the Department of Human Services or to a licensed
9 hospital which provides substance abuse treatment services.
10 The Department of Healthcare and Family Services shall assure
11 coverage for the cost of treatment of the drug abuse or
12 addiction for pregnant recipients in accordance with the
13 Illinois Medicaid Program in conjunction with the Department of
14 Human Services.
15 All medical providers providing medical assistance to
16 pregnant women under this Code shall receive information from
17 the Department on the availability of services under the Drug
18 Free Families with a Future or any comparable program providing
19 case management services for addicted women, including
20 information on appropriate referrals for other social services
21 that may be needed by addicted women in addition to treatment
22 for addiction.
23 The Illinois Department, in cooperation with the
24 Departments of Human Services (as successor to the Department
25 of Alcoholism and Substance Abuse) and Public Health, through a
26 public awareness campaign, may provide information concerning

1 treatment for alcoholism and drug abuse and addiction, prenatal
2 health care, and other pertinent programs directed at reducing
3 the number of drug-affected infants born to recipients of
4 medical assistance.

5 Neither the Department of Healthcare and Family Services
6 nor the Department of Human Services shall sanction the
7 recipient solely on the basis of her substance abuse.

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

17 The Illinois Department may develop and contract with
18 Partnerships of medical providers to arrange medical services
19 for persons eligible under Section 5-2 of this Code.
20 Implementation of this Section may be by demonstration projects
21 in certain geographic areas. The Partnership shall be
22 represented by a sponsor organization. The Department, by rule,
23 shall develop qualifications for sponsors of Partnerships.
24 Nothing in this Section shall be construed to require that the
25 sponsor organization be a medical organization.

26 The sponsor must negotiate formal written contracts with

medical providers for physician services, inpatient and outpatient hospital care, home health services, treatment for alcoholism and substance abuse, and other services determined necessary by the Illinois Department by rule for delivery by Partnerships. Physician services must include prenatal and obstetrical care. The Illinois Department shall reimburse medical services delivered by Partnership providers to clients in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

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

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

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

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the delivery of high quality medical services. These qualifications shall be determined by rule of the Illinois Department and may be higher than qualifications for

1 participation in the medical assistance program. Partnership
2 sponsors may prescribe reasonable additional qualifications
3 for participation by medical providers, only with the prior
4 written approval of the Illinois Department.

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

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

17 The Illinois Department shall require health care
18 providers to maintain records that document the medical care
19 and services provided to recipients of Medical Assistance under
20 this Article. Such records must be retained for a period of not
21 less than 6 years from the date of service or as provided by
22 applicable State law, whichever period is longer, except that
23 if an audit is initiated within the required retention period
24 then the records must be retained until the audit is completed
25 and every exception is resolved. The Illinois Department shall
26 require health care providers to make available, when

1 authorized by the patient, in writing, the medical records in a
2 timely fashion to other health care providers who are treating
3 or serving persons eligible for Medical Assistance under this
4 Article. All dispensers of medical services shall be required
5 to maintain and retain business and professional records
6 sufficient to fully and accurately document the nature, scope,
7 details and receipt of the health care provided to persons
8 eligible for medical assistance under this Code, in accordance
9 with regulations promulgated by the Illinois Department. The
10 rules and regulations shall require that proof of the receipt
11 of prescription drugs, dentures, prosthetic devices and
12 eyeglasses by eligible persons under this Section accompany
13 each claim for reimbursement submitted by the dispenser of such
14 medical services. No such claims for reimbursement shall be
15 approved for payment by the Illinois Department without such
16 proof of receipt, unless the Illinois Department shall have put
17 into effect and shall be operating a system of post-payment
18 audit and review which shall, on a sampling basis, be deemed
19 adequate by the Illinois Department to assure that such drugs,
20 dentures, prosthetic devices and eyeglasses for which payment
21 is being made are actually being received by eligible
22 recipients. Within 90 days after the effective date of this
23 amendatory Act of 1984, the Illinois Department shall establish
24 a current list of acquisition costs for all prosthetic devices
25 and any other items recognized as medical equipment and
26 supplies reimbursable under this Article and shall update such

list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after July 22, 2013~~,~~ (the effective date of Public Act 98-104), establish procedures to permit skilled care facilities licensed under the Nursing Home Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after August 15, 2014 (the effective date of Public Act 98-963) ~~this amendatory Act of the 98th General Assembly~~, establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department

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

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

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

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

Unless otherwise specified, such termination of eligibility or disenrollment is not subject to the Department's hearing process. However, a disenrolled vendor may reapply without penalty.

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

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

The Department shall define or specify the following: (i) by provider notice, the "category of risk of the vendor" for each type of vendor, which shall take into account the level of screening applicable to a particular category of vendor under federal law and regulations; (ii) by rule or provider notice, the maximum length of the conditional enrollment period for each category of risk of the vendor; and (iii) by rule, the

hearing rights, if any, afforded to a vendor in each category of risk of the vendor that is terminated or disenrolled during the conditional enrollment period.

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

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

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

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

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

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

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

25 Claims that are not submitted and received in compliance
26 with the foregoing requirements shall not be eligible for

1 payment under the medical assistance program, and the State
2 shall have no liability for payment of those claims.
3 To the extent consistent with applicable information and
4 privacy, security, and disclosure laws, State and federal
5 agencies and departments shall provide the Illinois Department
6 access to confidential and other information and data necessary
7 to perform eligibility and payment verifications and other
8 Illinois Department functions. This includes, but is not
9 limited to: information pertaining to licensure;
10 certification; earnings; immigration status; citizenship; wage
11 reporting; unearned and earned income; pension income;
12 employment; supplemental security income; social security
13 numbers; National Provider Identifier (NPI) numbers; the
14 National Practitioner Data Bank (NPDB); program and agency
15 exclusions; taxpayer identification numbers; tax delinquency;
16 corporate information; and death records.
17 The Illinois Department shall enter into agreements with
18 State agencies and departments, and is authorized to enter into
19 agreements with federal agencies and departments, under which
20 such agencies and departments shall share data necessary for
21 medical assistance program integrity functions and oversight.
22 The Illinois Department shall develop, in cooperation with
23 other State departments and agencies, and in compliance with
24 applicable federal laws and regulations, appropriate and
25 effective methods to share such data. At a minimum, and to the
26 extent necessary to provide data sharing, the Illinois

1 Department shall enter into agreements with State agencies and
2 departments, and is authorized to enter into agreements with
3 federal agencies and departments, including but not limited to:
4 the Secretary of State; the Department of Revenue; the
5 Department of Public Health; the Department of Human Services;
6 and the Department of Financial and Professional Regulation.

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

21 The Illinois Department shall establish policies,
22 procedures, standards and criteria by rule for the acquisition,
23 repair and replacement of orthotic and prosthetic devices and
24 durable medical equipment. Such rules shall provide, but not be
25 limited to, the following services: (1) immediate repair or
26 replacement of such devices by recipients; and (2) rental,

1 lease, purchase or lease-purchase of durable medical equipment
2 in a cost-effective manner, taking into consideration the
3 recipient's medical prognosis, the extent of the recipient's
4 needs, and the requirements and costs for maintaining such
5 equipment. Subject to prior approval, such rules shall enable a
6 recipient to temporarily acquire and use alternative or
7 substitute devices or equipment pending repairs or
8 replacements of any device or equipment previously authorized
9 for such recipient by the Department.

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

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

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

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

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

26 (b) actual statistics and trends in the provision of

1 the various medical services by medical vendors;
2 (c) current rate structures and proposed changes in
3 those rate structures for the various medical vendors; and
4 (d) efforts at utilization review and control by the
5 Illinois Department.
6 The period covered by each report shall be the 3 years
7 ending on the June 30 prior to the report. The report shall
8 include suggested legislation for consideration by the General
9 Assembly. The filing of one copy of the report with the
10 Speaker, one copy with the Minority Leader and one copy with
11 the Clerk of the House of Representatives, one copy with the
12 President, one copy with the Minority Leader and one copy with
13 the Secretary of the Senate, one copy with the Legislative
14 Research Unit, and such additional copies with the State
15 Government Report Distribution Center for the General Assembly
16 as is required under paragraph (t) of Section 7 of the State
17 Library Act shall be deemed sufficient to comply with this
18 Section.
19 Rulemaking authority to implement Public Act 95-1045, if
20 any, is conditioned on the rules being adopted in accordance
21 with all provisions of the Illinois Administrative Procedure
22 Act and all rules and procedures of the Joint Committee on
23 Administrative Rules; any purported rule not so adopted, for
24 whatever reason, is unauthorized.
25 On and after July 1, 2012, the Department shall reduce any
26 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, cost
5 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 (Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689,
21 eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section
22 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff.
23 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651,
24 eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14;
25 revised 10-2-14.)

1 (305 ILCS 5/12-4.49 new)
2 Sec. 12-4.49. Medicaid Pilot Program for Diabetes
3 Self-Management Training.
4 (a) Legislative findings. It is the intent of the General
5 Assembly to ensure that the State can help reduce Medicaid
6 healthcare costs associated with the treatment of diabetes and
7 its related complications. Diabetes education is a service that
8 is underutilized and not readily available. Unlike most other
9 chronic health conditions, diabetes treatment deeply relies on
10 education to enhance self-management of the disease. A
11 qualified diabetes educator can help. As a member of a
12 healthcare team, a diabetes educator works with patients to
13 develop a plan to stay healthy and to give them the tools and
14 ongoing support to make that plan a regular part of their
15 lives. Studies have found that teaching patients how to
16 effectively control their diabetes through self-management is
17 considered one of the most important and cost-effective tools
18 in the arsenal of diabetes treatment in order to avoid the
19 deadly and costly comorbidities associated with the disease.
20 To test whether inpatient diabetes education can reduce the
21 State's healthcare costs and improve overall health, the
22 General Assembly finds that a Medicaid Pilot Program for
23 Diabetes Self-Management Training utilizing qualified diabetes
24 educators is needed to achieve these goals.
25 (b) Pilot program. The Department of Healthcare and Family
26 Services shall establish a 2-year countywide Medicaid Pilot

1 Program for Diabetes Self-Management Training that covers
2 consultation sessions on blood glucose monitoring, dietary
3 restrictions and options, lifestyle modification, family and
4 community support roles, early appropriate insulin or other
5 medication initiation and administration, and awareness of
6 specific disease-related conditions, including hypoglycemia.
7 (c) Reimbursement formula. When a qualified diabetes
8 educator, who is under the direction of a physician and has the
9 legal authority to treat a patient with diabetes, is required
10 to assist in the titration of insulin therapy for a patient,
11 the reimbursement formula for the qualified diabetes educator
12 shall be at a rate no less than the median rate paid by the
13 commercial insurers in the private market as identified by the
14 Department of Insurance. The pilot program may allow services
15 from nonprofit organizations.
16 (d) AADE. The Department of Healthcare and Family services
17 shall develop more than one pilot program in consultation with
18 the American Association of Diabetes Educators (AADE) and with
19 any other group of qualified diabetes educators.
20 (e) Required competencies. The required competencies for
21 qualified diabetes educators shall meet the standards
22 established in the AADE's "Guidelines for the Practice of
23 Diabetes Self-Management Training (DSME/T)".
24 (f) Diabetes education. Quality diabetes education shall
25 meet the standards established in the AADE's "Competencies for
26 Diabetes Educators: A Companion Document to the Diabetes

1 Educator Practice Levels" to ensure that the designation
2 "diabetes educator" includes healthcare professionals who have
3 achieved a core body of knowledge and skills in communication,
4 counseling, and education and in the biological and social
5 sciences, and who have experience in the care of people with
6 diabetes.
7 (g) Work experience. Quality and qualified diabetes
8 educators must complete 250 hours of diabetes
9 self-management-training-related work experience within a
10 2-year timeframe and must meet practice standards based on
11 State or local regulations for specific healthcare
12 disciplines.
13 (h) Continuing education. Quality and qualified diabetes
14 educators must complete 40 hours of continuing education
15 related to diabetes or diabetes self-management training
16 within a 2-year timeframe.
17 (i) Final report. The pilot program shall operate for 2
18 years. At the end of the 2-year period the Department shall
19 submit a final report to the General Assembly that provides a
20 comparison analysis of the results of the various county pilot
21 programs to the healthcare results of counties of a comparable
22 size that do not provide the diabetes services offered under
23 the pilot program. The report shall also include guidance,
24 recommendations, and best practices on how to lower glucose
25 levels and treat hypoglycemia.

26 Section 99. Effective date. This Act takes effect January

1 1, 2016.