



Rep. Barbara Flynn Currie

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1 AMENDMENT TO SENATE BILL 420

2 AMENDMENT NO. _____. Amend Senate Bill 420 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 (Text of Section before amendment by P.A. 99-407)

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

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

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

24 Notwithstanding any other provision of this Section, a
25 comprehensive tobacco use cessation program that includes
26 purchasing prescription drugs or prescription medical devices

1 approved by the Food and Drug Administration shall be covered
2 under the medical assistance program under this Article for
3 persons who are otherwise eligible for assistance under this
4 Article.

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

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

1 Department or the MCE in which the individual is enrolled for
2 payment and shall be reimbursed at the Department's or the
3 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

1 this provision.

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

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

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

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

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

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

26 (D) A comprehensive ultrasound screening of an entire

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

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

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

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 drug abuse or is addicted as
12 defined in the Alcoholism and Other Drug Abuse and Dependency
13 Act, referral to a local substance abuse treatment provider
14 licensed by the Department of Human Services or to a licensed
15 hospital which provides substance abuse treatment services.
16 The Department of Healthcare and Family Services shall assure
17 coverage for the cost of treatment of the drug abuse or
18 addiction for pregnant recipients in accordance with the
19 Illinois Medicaid Program in conjunction with the Department of
20 Human Services.

21 All medical providers providing medical assistance to
22 pregnant women under this Code shall receive information from
23 the Department on the availability of services under the Drug
24 Free Families with a Future or any comparable program providing
25 case management services for addicted women, including
26 information on appropriate referrals for other social services

1 that may be needed by addicted women in addition to treatment
2 for addiction.

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

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

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

23 The Illinois Department may develop and contract with
24 Partnerships of medical providers to arrange medical services
25 for persons eligible under Section 5-2 of this Code.
26 Implementation of this Section may be by demonstration projects

1 in certain geographic areas. The Partnership shall be
2 represented by a sponsor organization. The Department, by rule,
3 shall develop qualifications for sponsors of Partnerships.
4 Nothing in this Section shall be construed to require that the
5 sponsor organization be a medical organization.

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

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

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

24 (3) Persons receiving medical services through
25 Partnerships may receive medical and case management
26 services above the level usually offered through the

1 medical assistance program.

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

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

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

23 The Illinois Department shall require health care
24 providers to maintain records that document the medical care
25 and services provided to recipients of Medical Assistance under
26 this Article. Such records must be retained for a period of not

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

1 is being made are actually being received by eligible
2 recipients. Within 90 days after September 16, 1984 (the
3 effective date of Public Act 83-1439) ~~this amendatory Act of~~
4 ~~1984~~, the Illinois Department shall establish a current list of
5 acquisition costs for all prosthetic devices and any other
6 items recognized as medical equipment and supplies
7 reimbursable under this Article and shall update such list on a
8 quarterly basis, except that the acquisition costs of all
9 prescription drugs shall be updated no less frequently than
10 every 30 days as required by Section 5-5.12.

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

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

1 home claims.

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

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

21 The Illinois Department may require that all dispensers of
22 medical services desiring to participate in the medical
23 assistance program established under this Article disclose,
24 under such terms and conditions as the Illinois Department may
25 by rule establish, all inquiries from clients and attorneys
26 regarding medical bills paid by the Illinois Department, which

1 inquiries could indicate potential existence of claims or liens
2 for the Illinois Department.

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

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

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

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

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

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

23 (2) In the case of errors attributable to the Illinois
24 Department or any of its claims processing intermediaries
25 which result in an inability to receive, process, or
26 adjudicate a claim, the 180-day period shall not begin

1 until the provider has been notified of the error.

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

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

8 For claims for services rendered during a period for which
9 a recipient received retroactive eligibility, claims must be
10 filed within 180 days after the Department determines the
11 applicant is eligible. For claims for which the Illinois
12 Department is not the primary payer, claims must be submitted
13 to the Illinois Department within 180 days after the final
14 adjudication by the primary payer.

15 In the case of long term care facilities, within 5 days of
16 receipt by the facility of required prescreening information,
17 data for new admissions shall be entered into the Medical
18 Electronic Data Interchange (MEDI) or the Recipient
19 Eligibility Verification (REV) System or successor system, and
20 within 15 days of receipt by the facility of required
21 prescreening information, admission documents shall be
22 submitted through MEDI or REV or shall be submitted directly to
23 the Department of Human Services using required admission
24 forms. Effective September 1, 2014, admission documents,
25 including all prescreening information, must be submitted
26 through MEDI or REV. Confirmation numbers assigned to an

1 accepted transaction shall be retained by a facility to verify
2 timely submittal. Once an admission transaction has been
3 completed, all resubmitted claims following prior rejection
4 are subject to receipt no later than 180 days after the
5 admission transaction has been completed.

6 Claims that are not submitted and received in compliance
7 with the foregoing requirements shall not be eligible for
8 payment under the medical assistance program, and the State
9 shall have no liability for payment of those claims.

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

24 The Illinois Department shall enter into agreements with
25 State agencies and departments, and is authorized to enter into
26 agreements with federal agencies and departments, under which

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

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

1 take any action or acquire any products or services.

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

21 The Department shall require, by rule, all providers of
22 durable medical equipment to be accredited by an accreditation
23 organization approved by the federal Centers for Medicare and
24 Medicaid Services and recognized by the Department in order to
25 bill the Department for providing durable medical equipment to
26 recipients. No later than 15 months after the effective date of

1 the rule adopted pursuant to this paragraph, all providers must
2 meet the accreditation requirement.

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

1 workgroup that includes affected agency representatives and
2 stakeholders representing the institutional and home and
3 community-based long term care interests. This Section shall
4 not restrict the Department from implementing lower level of
5 care eligibility criteria for community-based services in
6 circumstances where federal approval has been granted.

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

14 The Illinois Department shall report annually to the
15 General Assembly, no later than the second Friday in April of
16 1979 and each year thereafter, in regard to:

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

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

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

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

25 The period covered by each report shall be the 3 years
26 ending on the June 30 prior to the report. The report shall

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

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

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

23 Because kidney transplantation can be an appropriate, cost
24 effective alternative to renal dialysis when medically
25 necessary and notwithstanding the provisions of Section 1-11 of
26 this Code, beginning October 1, 2014, the Department shall

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

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

24 On or after July 1, 2015, opioid antagonists prescribed for
25 the treatment of an opioid overdose, including the medication
26 product, administration devices, and any pharmacy fees related

1 to the dispensing and administration of the opioid antagonist,
2 shall be covered under the medical assistance program for
3 persons who are otherwise eligible for medical assistance under
4 this Article. As used in this Section, "opioid antagonist"
5 means a drug that binds to opioid receptors and blocks or
6 inhibits the effect of opioids acting on those receptors,
7 including, but not limited to, naloxone hydrochloride or any
8 other similarly acting drug approved by the U.S. Food and Drug
9 Administration.

10 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
11 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
12 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
13 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
14 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-433, eff.
15 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

16 (Text of Section after amendment by P.A. 99-407)

17 Sec. 5-5. Medical services. The Illinois Department, by
18 rule, shall determine the quantity and quality of and the rate
19 of reimbursement for the medical assistance for which payment
20 will be authorized, and the medical services to be provided,
21 which may include all or part of the following: (1) inpatient
22 hospital services; (2) outpatient hospital services; (3) other
23 laboratory and X-ray services; (4) skilled nursing home
24 services; (5) physicians' services whether furnished in the
25 office, the patient's home, a hospital, a skilled nursing home,

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

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

24 Notwithstanding any other provision of this Section, a
25 comprehensive tobacco use cessation program that includes
26 purchasing prescription drugs or prescription medical devices

1 approved by the Food and Drug Administration shall be covered
2 under the medical assistance program under this Article for
3 persons who are otherwise eligible for assistance under this
4 Article.

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

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

1 Department or the MCE in which the individual is enrolled for
2 payment and shall be reimbursed at the Department's or the
3 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

1 this provision.

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

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

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

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

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

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

26 (D) A comprehensive ultrasound screening of an entire

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

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

8 All screenings shall include a physical breast exam,
9 instruction on self-examination and information regarding the
10 frequency of self-examination and its value as a preventative
11 tool. For purposes of this Section, "low-dose mammography"
12 means the x-ray examination of the breast using equipment
13 dedicated specifically for mammography, including the x-ray
14 tube, filter, compression device, and image receptor, with an
15 average radiation exposure delivery of less than one rad per
16 breast for 2 views of an average size breast. The term also
17 includes digital mammography and includes breast
18 tomosynthesis. As used in this Section, the term "breast
19 tomosynthesis" means a radiologic procedure that involves the
20 acquisition of projection images over the stationary breast to
21 produce cross-sectional digital three-dimensional images of
22 the breast.

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

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

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

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

16 The Department shall convene an expert panel, including
17 representatives of hospitals, free standing breast cancer
18 treatment centers, breast cancer quality organizations, and
19 doctors, including breast surgeons, reconstructive breast
20 surgeons, oncologists, and primary care providers to establish
21 quality standards for breast cancer treatment.

22 Subject to federal approval, the Department shall
23 establish a rate methodology for mammography at federally
24 qualified health centers and other encounter-rate clinics.
25 These clinics or centers may also collaborate with other
26 hospital-based mammography facilities. By January 1, 2016, the

1 Department shall report to the General Assembly on the status
2 of the provision set forth in this paragraph.

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

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. On or after July 1,
25 2016, the pilot program shall be expanded to include one site
26 in western Illinois, one site in southern Illinois, one site in

1 central Illinois, and 4 sites within metropolitan Chicago. An
2 evaluation of the pilot program shall be carried out measuring
3 health outcomes and cost of care for those served by the pilot
4 program compared to similarly situated patients who are not
5 served by the pilot program.

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

14 Any medical or health care provider shall immediately
15 recommend, to any pregnant woman who is being provided prenatal
16 services and is suspected of drug abuse or is addicted as
17 defined in the Alcoholism and Other Drug Abuse and Dependency
18 Act, referral to a local substance abuse treatment provider
19 licensed by the Department of Human Services or to a licensed
20 hospital which provides substance abuse treatment services.
21 The Department of Healthcare and Family Services shall assure
22 coverage for the cost of treatment of the drug abuse or
23 addiction for pregnant recipients in accordance with the
24 Illinois Medicaid Program in conjunction with the Department of
25 Human Services.

26 All medical providers providing medical assistance to

1 pregnant women under this Code shall receive information from
2 the Department on the availability of services under the Drug
3 Free Families with a Future or any comparable program providing
4 case management services for addicted women, including
5 information on appropriate referrals for other social services
6 that may be needed by addicted women in addition to treatment
7 for addiction.

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

16 Neither the Department of Healthcare and Family Services
17 nor the Department of Human Services shall sanction the
18 recipient solely on the basis of her substance abuse.

19 The Illinois Department shall establish such regulations
20 governing the dispensing of health services under this Article
21 as it shall deem appropriate. The Department should seek the
22 advice of formal professional advisory committees appointed by
23 the Director of the Illinois Department for the purpose of
24 providing regular advice on policy and administrative matters,
25 information dissemination and educational activities for
26 medical and health care providers, and consistency in

1 procedures to the Illinois Department.

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

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

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

26 (2) The Department may elect to consider and negotiate

1 financial incentives to encourage the development of
2 Partnerships and the efficient delivery of medical care.

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

7 Medical providers shall be required to meet certain
8 qualifications to participate in Partnerships to ensure the
9 delivery of high quality medical services. These
10 qualifications shall be determined by rule of the Illinois
11 Department and may be higher than qualifications for
12 participation in the medical assistance program. Partnership
13 sponsors may prescribe reasonable additional qualifications
14 for participation by medical providers, only with the prior
15 written approval of the Illinois Department.

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

25 The Department shall apply for a waiver from the United
26 States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.

2 The Illinois Department shall require health care
3 providers to maintain records that document the medical care
4 and services provided to recipients of Medical Assistance under
5 this Article. Such records must be retained for a period of not
6 less than 6 years from the date of service or as provided by
7 applicable State law, whichever period is longer, except that
8 if an audit is initiated within the required retention period
9 then the records must be retained until the audit is completed
10 and every exception is resolved. The Illinois Department shall
11 require health care providers to make available, when
12 authorized by the patient, in writing, the medical records in a
13 timely fashion to other health care providers who are treating
14 or serving persons eligible for Medical Assistance under this
15 Article. All dispensers of medical services shall be required
16 to maintain and retain business and professional records
17 sufficient to fully and accurately document the nature, scope,
18 details and receipt of the health care provided to persons
19 eligible for medical assistance under this Code, in accordance
20 with regulations promulgated by the Illinois Department. The
21 rules and regulations shall require that proof of the receipt
22 of prescription drugs, dentures, prosthetic devices and
23 eyeglasses by eligible persons under this Section accompany
24 each claim for reimbursement submitted by the dispenser of such
25 medical services. No such claims for reimbursement shall be
26 approved for payment by the Illinois Department without such

1 proof of receipt, unless the Illinois Department shall have put
2 into effect and shall be operating a system of post-payment
3 audit and review which shall, on a sampling basis, be deemed
4 adequate by the Illinois Department to assure that such drugs,
5 dentures, prosthetic devices and eyeglasses for which payment
6 is being made are actually being received by eligible
7 recipients. Within 90 days after September 16, 1984 (the
8 effective date of Public Act 83-1439) ~~this amendatory Act of~~
9 ~~1984~~, the Illinois Department shall establish a current list of
10 acquisition costs for all prosthetic devices and any other
11 items recognized as medical equipment and supplies
12 reimbursable under this Article and shall update such list on a
13 quarterly basis, except that the acquisition costs of all
14 prescription drugs shall be updated no less frequently than
15 every 30 days as required by Section 5-5.12.

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

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

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

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

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

26 The Illinois Department may require that all dispensers of

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

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

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

20 Prior to enrollment and during the conditional enrollment
21 period in the medical assistance program, all vendors shall be
22 subject to enhanced oversight, screening, and review based on
23 the risk of fraud, waste, and abuse that is posed by the
24 category of risk of the vendor. The Illinois Department shall
25 establish the procedures for oversight, screening, and review,
26 which may include, but need not be limited to: criminal and

1 financial background checks; fingerprinting; license,
2 certification, and authorization verifications; unscheduled or
3 unannounced site visits; database checks; prepayment audit
4 reviews; audits; payment caps; payment suspensions; and other
5 screening as required by federal or State law.

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

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

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

1 complete.

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

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

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

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

20 In the case of long term care facilities, within 5 days of
21 receipt by the facility of required prescreening information,
22 data for new admissions shall be entered into the Medical
23 Electronic Data Interchange (MEDI) or the Recipient
24 Eligibility Verification (REV) System or successor system, and
25 within 15 days of receipt by the facility of required
26 prescreening information, admission documents shall be

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

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

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

1 exclusions; taxpayer identification numbers; tax delinquency;
2 corporate information; and death records.

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

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

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

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

26 The Department shall require, by rule, all providers of

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

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

1 1, 2013, establish procedures to permit long term care
2 providers access to eligibility scores for individuals with an
3 admission date who are seeking or receiving services from the
4 long term care provider. In order to select the minimum level
5 of care eligibility criteria, the Governor shall establish a
6 workgroup that includes affected agency representatives and
7 stakeholders representing the institutional and home and
8 community-based long term care interests. This Section shall
9 not restrict the Department from implementing lower level of
10 care eligibility criteria for community-based services in
11 circumstances where federal approval has been granted.

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

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

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

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

26 (c) current rate structures and proposed changes in

1 those rate structures for the various medical vendors; and

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

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

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

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

1 Section 5-5e.

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

18 Notwithstanding any other provision of this Code to the
19 contrary, on or after July 1, 2015, all FDA approved forms of
20 medication assisted treatment prescribed for the treatment of
21 alcohol dependence or treatment of opioid dependence shall be
22 covered under both fee for service and managed care medical
23 assistance programs for persons who are otherwise eligible for
24 medical assistance under this Article and shall not be subject
25 to any (1) utilization control, other than those established
26 under the American Society of Addiction Medicine patient

1 placement criteria, (2) prior authorization mandate, or (3)
2 lifetime restriction limit mandate.

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

15 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
16 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
17 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
18 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
19 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
20 99 of P.A. 99-407 for its effective date); 99-433, eff.
21 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

22 Section 95. No acceleration or delay. Where this Act makes
23 changes in a statute that is represented in this Act by text
24 that is not yet or no longer in effect (for example, a Section
25 represented by multiple versions), the use of that text does

1 not accelerate or delay the taking effect of (i) the changes
2 made by this Act or (ii) provisions derived from any other
3 Public Act.".