HB2908

LRB10011344KTG21724b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB2908

by Rep. Patricia R. Bellock

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5 from Ch. 23, par. 5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. In provisions concerning medical assistance for the treatment of alcohol dependence or opioid dependence, provides that on or after July 1, 2017 such coverage may be subject to utilization controls or prior authorization mandates consistent with the most current edition of the American Society of Addiction Medicine's National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, as now or hereafter revised, or any successor publication (rather than on or after July 1, 2015 such coverage shall not be subject to any (1) utilization control, other than those established under the American Society of Addiction Medicine patient placement criteria, (2) prior authorization mandate, or (3) lifetime restriction limit mandate). Provides that on or after July 1, 2017, opioid antagonists prescribed for the treatment of an opioid overdose may be subject to (A) utilization controls or (B) prior authorization mandates consistent with the most current edition of the American Society of Addiction Medicine's National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, as now or hereafter revised, or any successor publication.

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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 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 On and after July 1, 2012, the Department of Healthcare and
23 Family Services may provide the following services to persons
24 eligible for assistance under this Article who are
25 participating in education, training or employment programs
26 operated by the Department of Human Services as successor to

1 the Department of Public Aid:
2 (1) dental services provided by or under the
3 supervision of a dentist; and
4 (2) eyeglasses prescribed by a physician skilled in the
5 diseases of the eye, or by an optometrist, whichever the
6 person may select.
7 Notwithstanding any other provision of this Code and
8 subject to federal approval, the Department may adopt rules to
9 allow a dentist who is volunteering his or her service at no
10 cost to render dental services through an enrolled
11 not-for-profit health clinic without the dentist personally
12 enrolling as a participating provider in the medical assistance
13 program. A not-for-profit health clinic shall include a public
14 health clinic or Federally Qualified Health Center or other
15 enrolled provider, as determined by the Department, through
16 which dental services covered under this Section are performed.
17 The Department shall establish a process for payment of claims
18 for reimbursement for covered dental services rendered under
19 this provision.
20 The Illinois Department, by rule, may distinguish and
21 classify the medical services to be provided only in accordance
22 with the classes of persons designated in Section 5-2.
23 The Department of Healthcare and Family Services must
24 provide coverage and reimbursement for amino acid-based
25 elemental formulas, regardless of delivery method, for the
26 diagnosis and treatment of (i) eosinophilic disorders and (ii)

1 short bowel syndrome when the prescribing physician has issued
2 a written order stating that the amino acid-based elemental
3 formula is medically necessary.
4 The Illinois Department shall authorize the provision of,
5 and shall authorize payment for, screening by low-dose
6 mammography for the presence of occult breast cancer for women
7 35 years of age or older who are eligible for medical
8 assistance under this Article, as follows:
9 (A) A baseline mammogram for women 35 to 39 years of
10 age.
11 (B) An annual mammogram for women 40 years of age or
12 older.
13 (C) A mammogram at the age and intervals considered
14 medically necessary by the woman's health care provider for
15 women under 40 years of age and having a family history of
16 breast cancer, prior personal history of breast cancer,
17 positive genetic testing, or other risk factors.
18 (D) A comprehensive ultrasound screening of an entire
19 breast or breasts if a mammogram demonstrates
20 heterogeneous or dense breast tissue, when medically
21 necessary as determined by a physician licensed to practice
22 medicine in all of its branches.
23 (E) A screening MRI when medically necessary, as
24 determined by a physician licensed to practice medicine in
25 all of its branches.
26 All screenings shall include a physical breast exam,

1 instruction on self-examination and information regarding the
2 frequency of self-examination and its value as a preventative
3 tool. For purposes of this Section, "low-dose mammography"
4 means the x-ray examination of the breast using equipment
5 dedicated specifically for mammography, including the x-ray
6 tube, filter, compression device, and image receptor, with an
7 average radiation exposure delivery of less than one rad per
8 breast for 2 views of an average size breast. The term also
9 includes digital mammography and includes breast
10 tomosynthesis. As used in this Section, the term "breast
11 tomosynthesis" means a radiologic procedure that involves the
12 acquisition of projection images over the stationary breast to
13 produce cross-sectional digital three-dimensional images of
14 the breast. If, at any time, the Secretary of the United States
15 Department of Health and Human Services, or its successor
16 agency, promulgates rules or regulations to be published in the
17 Federal Register or publishes a comment in the Federal Register
18 or issues an opinion, guidance, or other action that would
19 require the State, pursuant to any provision of the Patient
20 Protection and Affordable Care Act (Public Law 111-148),
21 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
22 successor provision, to defray the cost of any coverage for
23 breast tomosynthesis outlined in this paragraph, then the
24 requirement that an insurer cover breast tomosynthesis is
25 inoperative other than any such coverage authorized under
26 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and

1 the State shall not assume any obligation for the cost of
2 coverage for breast tomosynthesis set forth in this paragraph.
3 On and after January 1, 2016, the Department shall ensure
4 that all networks of care for adult clients of the Department
5 include access to at least one breast imaging Center of Imaging
6 Excellence as certified by the American College of Radiology.
7 On and after January 1, 2012, providers participating in a
8 quality improvement program approved by the Department shall be
9 reimbursed for screening and diagnostic mammography at the same
10 rate as the Medicare program's rates, including the increased
11 reimbursement for digital mammography.
12 The Department shall convene an expert panel including
13 representatives of hospitals, free-standing mammography
14 facilities, and doctors, including radiologists, to establish
15 quality standards for mammography.
16 On and after January 1, 2017, providers participating in a
17 breast cancer treatment quality improvement program approved
18 by the Department shall be reimbursed for breast cancer
19 treatment at a rate that is no lower than 95% of the Medicare
20 program's rates for the data elements included in the breast
21 cancer treatment quality program.
22 The Department shall convene an expert panel, including
23 representatives of hospitals, free standing breast cancer
24 treatment centers, breast cancer quality organizations, and
25 doctors, including breast surgeons, reconstructive breast
26 surgeons, oncologists, and primary care providers to establish

quality standards for breast cancer treatment.

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

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

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

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program

1 in areas of the State with the highest incidence of mortality
2 related to breast cancer. At least one pilot program site shall
3 be in the metropolitan Chicago area and at least one site shall
4 be outside the metropolitan Chicago area. On or after July 1,
5 2016, the pilot program shall be expanded to include one site
6 in western Illinois, one site in southern Illinois, one site in
7 central Illinois, and 4 sites within metropolitan Chicago. An
8 evaluation of the pilot program shall be carried out measuring
9 health outcomes and cost of care for those served by the pilot
10 program compared to similarly situated patients who are not
11 served by the pilot program.

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

20 Any medical or health care provider shall immediately
21 recommend, to any pregnant woman who is being provided prenatal
22 services and is suspected of drug abuse or is addicted as
23 defined in the Alcoholism and Other Drug Abuse and Dependency
24 Act, referral to a local substance abuse treatment provider
25 licensed by the Department of Human Services or to a licensed
26 hospital which provides substance abuse treatment services.

1 The Department of Healthcare and Family Services shall assure
2 coverage for the cost of treatment of the drug abuse or
3 addiction for pregnant recipients in accordance with the
4 Illinois Medicaid Program in conjunction with the Department of
5 Human Services.
6 All medical providers providing medical assistance to
7 pregnant women under this Code shall receive information from
8 the Department on the availability of services under the Drug
9 Free Families with a Future or any comparable program providing
10 case management services for addicted women, including
11 information on appropriate referrals for other social services
12 that may be needed by addicted women in addition to treatment
13 for addiction.
14 The Illinois Department, in cooperation with the
15 Departments of Human Services (as successor to the Department
16 of Alcoholism and Substance Abuse) and Public Health, through a
17 public awareness campaign, may provide information concerning
18 treatment for alcoholism and drug abuse and addiction, prenatal
19 health care, and other pertinent programs directed at reducing
20 the number of drug-affected infants born to recipients of
21 medical assistance.
22 Neither the Department of Healthcare and Family Services
23 nor the Department of Human Services shall sanction the
24 recipient solely on the basis of her substance abuse.
25 The Illinois Department shall establish such regulations
26 governing the dispensing of health services under this Article

1 as it shall deem appropriate. The Department should seek the
2 advice of formal professional advisory committees appointed by
3 the Director of the Illinois Department for the purpose of
4 providing regular advice on policy and administrative matters,
5 information dissemination and educational activities for
6 medical and health care providers, and consistency in
7 procedures to the Illinois Department.

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

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

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

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

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

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

22 Nothing in this Section shall limit the free choice of
23 practitioners, hospitals, and other providers of medical
24 services by clients. In order to ensure patient freedom of
25 choice, the Illinois Department shall immediately promulgate
26 all rules and take all other necessary actions so that provided

services may be accessed from therapeutically certified optometrists to the full extent of the Illinois Optometric Practice Act of 1987 without discriminating between service providers.

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The

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

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

1 such medical services.

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

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

23 The Illinois Department shall require all dispensers of
24 medical services, other than an individual practitioner or
25 group of practitioners, desiring to participate in the Medical
26 Assistance program established under this Article to disclose

all financial, beneficial, ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services in this State under this Article.

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

Enrollment of a vendor shall be subject to a provisional period and shall be conditional for one year. During the period of conditional enrollment, the Department may terminate the vendor's eligibility to participate in, or may disenroll the 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

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

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

22 To be eligible for payment consideration, a vendor's
23 payment claim or bill, either as an initial claim or as a
24 resubmitted claim following prior rejection, must be received
25 by the Illinois Department, or its fiscal intermediary, no
26 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.

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

In the case of long term care facilities, within 5 days of

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

17 Claims that are not submitted and received in compliance
18 with the foregoing requirements shall not be eligible for
19 payment under the medical assistance program, and the State
20 shall have no liability for payment of those claims.

21 To the extent consistent with applicable information and
22 privacy, security, and disclosure laws, State and federal
23 agencies and departments shall provide the Illinois Department
24 access to confidential and other information and data necessary
25 to perform eligibility and payment verifications and other
26 Illinois Department functions. This includes, but is not

limited to: information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

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

Beginning in fiscal year 2013, the Illinois Department shall set forth a request for information to identify the

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

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

1 for such recipient by the Department. Notwithstanding any
2 provision of Section 5-5f to the contrary, the Department may,
3 by rule, exempt certain replacement wheelchair parts from prior
4 approval and, for wheelchairs, wheelchair parts, wheelchair
5 accessories, and related seating and positioning items,
6 determine the wholesale price by methods other than actual
7 acquisition costs.

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

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

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

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

1 The Illinois Department shall report annually to the
2 General Assembly, no later than the second Friday in April of
3 1979 and each year thereafter, in regard to:
4 (a) actual statistics and trends in utilization of
5 medical services by public aid recipients;
6 (b) actual statistics and trends in the provision of
7 the various medical services by medical vendors;
8 (c) current rate structures and proposed changes in
9 those rate structures for the various medical vendors; and
10 (d) efforts at utilization review and control by the
11 Illinois Department.
12 The period covered by each report shall be the 3 years
13 ending on the June 30 prior to the report. The report shall
14 include suggested legislation for consideration by the General
15 Assembly. The filing of one copy of the report with the
16 Speaker, one copy with the Minority Leader and one copy with
17 the Clerk of the House of Representatives, one copy with the
18 President, one copy with the Minority Leader and one copy with
19 the Secretary of the Senate, one copy with the Legislative
20 Research Unit, and such additional copies with the State
21 Government Report Distribution Center for the General Assembly
22 as is required under paragraph (t) of Section 7 of the State
23 Library Act shall be deemed sufficient to comply with this
24 Section.
25 Rulemaking authority to implement Public Act 95-1045, if
26 any, is conditioned on the rules being adopted in accordance

1 with all provisions of the Illinois Administrative Procedure
2 Act and all rules and procedures of the Joint Committee on
3 Administrative Rules; any purported rule not so adopted, for
4 whatever reason, is unauthorized.

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

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

26 Notwithstanding any other provision of this Code to the

contrary, on or after July 1, 2017 ~~2015~~, all FDA approved forms of medication assisted treatment prescribed for the treatment of alcohol dependence or treatment of opioid dependence shall be covered under both fee for service and managed care medical assistance programs for persons who are otherwise eligible for medical assistance under this Article and may ~~shall not~~ be subject to ~~any~~ (1) utilization controls or ~~control, other than those established under the American Society of Addiction Medicine patient placement criteria,~~ (2) prior authorization mandates consistent with the most current edition of the American Society of Addiction Medicine's National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, as now or hereafter revised, or any successor publication ~~mandate, or (3) lifetime restriction limit mandate~~.

On or after July 1, 2017 ~~2015~~, opioid antagonists prescribed for the treatment of an opioid overdose, including the medication product, administration devices, and any pharmacy fees related to the dispensing and administration of the opioid antagonist, shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article and may be subject to (1) utilization controls or (2) prior authorization mandates consistent with the most current edition of the American Society of Addiction Medicine's National Practice Guideline for the Use of Medications in the Treatment of Addiction

1 Involving Opioid Use, as now or hereafter revised, or any
2 successor publication. As used in this Section, "opioid
3 antagonist" means a drug that binds to opioid receptors and
4 blocks or inhibits the effect of opioids acting on those
5 receptors, including, but not limited to, naloxone
6 hydrochloride or any other similarly acting drug approved by
7 the U.S. Food and Drug Administration.

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

20 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
21 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
22 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
23 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
24 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section
25 20 of P.A. 99-588 for the effective date of P.A. 99-407);
26 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff.

1 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895,
2 eff. 1-1-17; revised 9-20-16.)