Sen. Laura Fine

Filed: 3/24/2023

1 AMENDMENT TO SENATE BILL 67

2 AMENDMENT NO. ______. Amend Senate Bill 67 on page 3,
3 immediately below line 4, by inserting the following:

4 "Section 10. 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
16 home, or elsewhere; (6) medical care, or any other type of

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

in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; (16.5) services performed by a chiropractic physician licensed under the Medical Practice Act of 1987 and acting within the scope of his or her license, including, but not limited to, chiropractic manipulative treatment; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

Notwithstanding any other provision of this Code, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article.

1 Notwithstanding any other provision of this Section, all
2 tobacco cessation medications approved by the United States
3 Food and Drug Administration and all individual and group
4 tobacco cessation counseling services and telephone-based
5 counseling services and tobacco cessation medications provided
6 through the Illinois Tobacco Quitline shall be covered under
7 the medical assistance program for persons who are otherwise
8 eligible for assistance under this Article. The Department
9 shall comply with all federal requirements necessary to obtain
10 federal financial participation, as specified in 42 CFR
11 433.15(b)(7), for telephone-based counseling services provided
12 through the Illinois Tobacco Quitline, including, but not
13 limited to: (i) entering into a memorandum of understanding or
14 interagency agreement with the Department of Public Health, as
15 administrator of the Illinois Tobacco Quitline; and (ii)
16 developing a cost allocation plan for Medicaid-allowable
17 Illinois Tobacco Quitline services in accordance with 45 CFR
18 95.507. The Department shall submit the memorandum of
19 understanding or interagency agreement, the cost allocation
20 plan, and all other necessary documentation to the Centers for
21 Medicare and Medicaid Services for review and approval.
22 Coverage under this paragraph shall be contingent upon federal
23 approval.
24 Notwithstanding any other provision of this Code, the
25 Illinois Department may not require, as a condition of payment
26 for any laboratory test authorized under this Article, that a

1 physician's handwritten signature appear on the laboratory
2 test order form. The Illinois Department may, however, impose
3 other appropriate requirements regarding laboratory test order
4 documentation.

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

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

1 operated by the Department of Human Services as successor to
2 the Department of Public Aid:
3 (1) dental services provided by or under the
4 supervision of a dentist; and
5 (2) eyeglasses prescribed by a physician skilled in
6 the diseases of the eye, or by an optometrist, whichever
7 the person may select.
8 On and after July 1, 2018, the Department of Healthcare
9 and Family Services shall provide dental services to any adult
10 who is otherwise eligible for assistance under the medical
11 assistance program. As used in this paragraph, "dental
12 services" means diagnostic, preventative, restorative, or
13 corrective procedures, including procedures and services for
14 the prevention and treatment of periodontal disease and dental
15 caries disease, provided by an individual who is licensed to
16 practice dentistry or dental surgery or who is under the
17 supervision of a dentist in the practice of his or her
18 profession.
19 On and after July 1, 2018, targeted dental services, as
20 set forth in Exhibit D of the Consent Decree entered by the
21 United States District Court for the Northern District of
22 Illinois, Eastern Division, in the matter of Memisovski v.
23 Maram, Case No. 92 C 1982, that are provided to adults under
24 the medical assistance program shall be established at no less
25 than the rates set forth in the "New Rate" column in Exhibit D
26 of the Consent Decree for targeted dental services that are

1 provided to persons under the age of 18 under the medical
2 assistance program.
3 Notwithstanding any other provision of this Code and
4 subject to federal approval, the Department may adopt rules to
5 allow a dentist who is volunteering his or her service at no
6 cost to render dental services through an enrolled
7 not-for-profit health clinic without the dentist personally
8 enrolling as a participating provider in the medical
9 assistance program. A not-for-profit health clinic shall
10 include a public health clinic or Federally Qualified Health
11 Center or other enrolled provider, as determined by the
12 Department, through which dental services covered under this
13 Section are performed. The Department shall establish a
14 process for payment of claims for reimbursement for covered
15 dental services rendered under this provision.
16 On and after January 1, 2022, the Department of Healthcare
17 and Family Services shall administer and regulate a
18 school-based dental program that allows for the out-of-office
19 delivery of preventative dental services in a school setting
20 to children under 19 years of age. The Department shall
21 establish, by rule, guidelines for participation by providers
22 and set requirements for follow-up referral care based on the
23 requirements established in the Dental Office Reference Manual
24 published by the Department that establishes the requirements
25 for dentists participating in the All Kids Dental School
26 Program. Every effort shall be made by the Department when

developing the program requirements to consider the different geographic differences of both urban and rural areas of the State for initial treatment and necessary follow-up care. No provider shall be charged a fee by any unit of local government to participate in the school-based dental program administered by the Department. Nothing in this paragraph shall be construed to limit or preempt a home rule unit's or school district's authority to establish, change, or administer a school-based dental program in addition to, or independent of, the school-based dental program administered by the Department.

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

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

The Illinois Department shall authorize the provision of, and shall authorize payment for, screening by low-dose mammography for the presence of occult breast cancer for individuals 35 years of age or older who are eligible for

1 medical assistance under this Article, as follows:
2 (A) A baseline mammogram for individuals 35 to 39
3 years of age.
4 (B) An annual mammogram for individuals 40 years of
5 age or older.
6 (C) A mammogram at the age and intervals considered
7 medically necessary by the individual's health care
8 provider for individuals under 40 years of age and having
9 a family history of breast cancer, prior personal history
10 of breast cancer, positive genetic testing, or other risk
11 factors.
12 (D) A comprehensive ultrasound screening and MRI of an
13 entire breast or breasts if a mammogram demonstrates
14 heterogeneous or dense breast tissue or when medically
15 necessary as determined by a physician licensed to
16 practice medicine in all of its branches.
17 (E) A screening MRI when medically necessary, as
18 determined by a physician licensed to practice medicine in
19 all of its branches.
20 (F) A diagnostic mammogram when medically necessary,
21 as determined by a physician licensed to practice medicine
22 in all its branches, advanced practice registered nurse,
23 or physician assistant.
24 The Department shall not impose a deductible, coinsurance,
25 copayment, or any other cost-sharing requirement on the
26 coverage provided under this paragraph; except that this

1 sentence does not apply to coverage of diagnostic mammograms
2 to the extent such coverage would disqualify a high-deductible
3 health plan from eligibility for a health savings account
4 pursuant to Section 223 of the Internal Revenue Code (26
5 U.S.C. 223).
6 All screenings shall include a physical breast exam,
7 instruction on self-examination and information regarding the
8 frequency of self-examination and its value as a preventative
9 tool.
10 For purposes of this Section:
11 "Diagnostic mammogram" means a mammogram obtained using
12 diagnostic mammography.
13 "Diagnostic mammography" means a method of screening that
14 is designed to evaluate an abnormality in a breast, including
15 an abnormality seen or suspected on a screening mammogram or a
16 subjective or objective abnormality otherwise detected in the
17 breast.
18 "Low-dose mammography" means the x-ray examination of the
19 breast using equipment dedicated specifically for mammography,
20 including the x-ray tube, filter, compression device, and
21 image receptor, with an average radiation exposure delivery of
22 less than one rad per breast for 2 views of an average size
23 breast. The term also includes digital mammography and
24 includes breast tomosynthesis.
25 "Breast tomosynthesis" means a radiologic procedure that
26 involves the acquisition of projection images over the

stationary breast to produce cross-sectional digital three-dimensional images of the breast.

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

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

On and after January 1, 2012, providers participating in a quality improvement program approved by the Department shall be reimbursed for screening and diagnostic mammography at the

same rate as the Medicare program's rates, including the increased reimbursement for digital mammography and, after <u>January 1, 2023 </u>(the effective date of <u>Public Act 102-1018)</u> ~~this amendatory Act of the 102nd General Assembly~~, breast tomosynthesis.

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

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

The Department shall convene an expert panel, including representatives of hospitals, free-standing breast cancer treatment centers, breast cancer quality organizations, and doctors, including breast surgeons, reconstructive breast 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 individuals 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 in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. On or after July 1, 2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern

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

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

The Department shall provide coverage and reimbursement for a human papillomavirus (HPV) vaccine that is approved for marketing by the federal Food and Drug Administration for all persons between the ages of 9 and 45 and persons of the age of 46 and above who have been diagnosed with cervical dysplasia with a high risk of recurrence or progression. The Department shall disallow any preauthorization requirements for the administration of the human papillomavirus (HPV) vaccine.

On or after July 1, 2022, individuals who are otherwise eligible for medical assistance under this Article shall receive coverage for perinatal depression screenings for the 12-month period beginning on the last day of their pregnancy. Medical assistance coverage under this paragraph shall be

1 conditioned on the use of a screening instrument approved by
2 the Department.
3 Any medical or health care provider shall immediately
4 recommend, to any pregnant individual who is being provided
5 prenatal services and is suspected of having a substance use
6 disorder as defined in the Substance Use Disorder Act,
7 referral to a local substance use disorder treatment program
8 licensed by the Department of Human Services or to a licensed
9 hospital which provides substance abuse treatment services.
10 The Department of Healthcare and Family Services shall assure
11 coverage for the cost of treatment of the drug abuse or
12 addiction for pregnant recipients in accordance with the
13 Illinois Medicaid Program in conjunction with the Department
14 of Human Services.
15 All medical providers providing medical assistance to
16 pregnant individuals under this Code shall receive information
17 from the Department on the availability of services under any
18 program providing case management services for addicted
19 individuals, including information on appropriate referrals
20 for other social services that may be needed by addicted
21 individuals in addition to treatment for addiction.
22 The Illinois Department, in cooperation with the
23 Departments of Human Services (as successor to the Department
24 of Alcoholism and Substance Abuse) and Public Health, through
25 a public awareness campaign, may provide information
26 concerning treatment for alcoholism and drug abuse and

addiction, prenatal health care, and other pertinent programs directed at reducing the number of drug-affected infants born to recipients of medical assistance.

Neither the Department of Healthcare and Family Services nor the Department of Human Services shall sanction the recipient solely on the basis of the recipient's substance abuse.

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

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

1 The sponsor must negotiate formal written contracts with
2 medical providers for physician services, inpatient and
3 outpatient hospital care, home health services, treatment for
4 alcoholism and substance abuse, and other services determined
5 necessary by the Illinois Department by rule for delivery by
6 Partnerships. Physician services must include prenatal and
7 obstetrical care. The Illinois Department shall reimburse
8 medical services delivered by Partnership providers to clients
9 in target areas according to provisions of this Article and
10 the Illinois Health Finance Reform Act, except that:
11 (1) Physicians participating in a Partnership and
12 providing certain services, which shall be determined by
13 the Illinois Department, to persons in areas covered by
14 the Partnership may receive an additional surcharge for
15 such services.
16 (2) The Department may elect to consider and negotiate
17 financial incentives to encourage the development of
18 Partnerships and the efficient delivery of medical care.
19 (3) Persons receiving medical services through
20 Partnerships may receive medical and case management
21 services above the level usually offered through the
22 medical assistance program.
23 Medical providers shall be required to meet certain
24 qualifications to participate in Partnerships to ensure the
25 delivery of high quality medical services. These
26 qualifications shall be determined by rule of the Illinois

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

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

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

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

1 Illinois Department shall require health care providers to
2 make available, when authorized by the patient, in writing,
3 the medical records in a timely fashion to other health care
4 providers who are treating or serving persons eligible for
5 Medical Assistance under this Article. All dispensers of
6 medical services shall be required to maintain and retain
7 business and professional records sufficient to fully and
8 accurately document the nature, scope, details and receipt of
9 the health care provided to persons eligible for medical
10 assistance under this Code, in accordance with regulations
11 promulgated by the Illinois Department. The rules and
12 regulations shall require that proof of the receipt of
13 prescription drugs, dentures, prosthetic devices and
14 eyeglasses by eligible persons under this Section accompany
15 each claim for reimbursement submitted by the dispenser of
16 such medical services. No such claims for reimbursement shall
17 be approved for payment by the Illinois Department without
18 such proof of receipt, unless the Illinois Department shall
19 have put into effect and shall be operating a system of
20 post-payment audit and review which shall, on a sampling
21 basis, be deemed adequate by the Illinois Department to assure
22 that such drugs, dentures, prosthetic devices and eyeglasses
23 for which payment is being made are actually being received by
24 eligible recipients. Within 90 days after September 16, 1984
25 (the effective date of Public Act 83-1439), the Illinois
26 Department shall establish a current list of acquisition costs

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

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

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

1 operational or structural changes to its information
2 technology platforms are implemented.
3 The Illinois Department shall require all dispensers of
4 medical services, other than an individual practitioner or
5 group of practitioners, desiring to participate in the Medical
6 Assistance program established under this Article to disclose
7 all financial, beneficial, ownership, equity, surety or other
8 interests in any and all firms, corporations, partnerships,
9 associations, business enterprises, joint ventures, agencies,
10 institutions or other legal entities providing any form of
11 health care services in this State under this Article.
12 The Illinois Department may require that all dispensers of
13 medical services desiring to participate in the medical
14 assistance program established under this Article disclose,
15 under such terms and conditions as the Illinois Department may
16 by rule establish, all inquiries from clients and attorneys
17 regarding medical bills paid by the Illinois Department, which
18 inquiries could indicate potential existence of claims or
19 liens for the Illinois Department.
20 Enrollment of a vendor shall be subject to a provisional
21 period and shall be conditional for one year. During the
22 period of conditional enrollment, the Department may terminate
23 the vendor's eligibility to participate in, or may disenroll
24 the vendor from, the medical assistance program without cause.
25 Unless otherwise specified, such termination of eligibility or
26 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 the category of risk of the vendor.

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

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

1 the conditional enrollment period.

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

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

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

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

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

25 For claims for services rendered during a period for which
26 a recipient received retroactive eligibility, claims must be

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

6 In the case of long term care facilities, within 120
7 calendar days of receipt by the facility of required
8 prescreening information, new admissions with associated
9 admission documents shall be submitted through the Medical
10 Electronic Data Interchange (MEDI) or the Recipient
11 Eligibility Verification (REV) System or shall be submitted
12 directly to the Department of Human Services using required
13 admission forms. Effective September 1, 2014, admission
14 documents, including all prescreening information, must be
15 submitted through MEDI or REV. Confirmation numbers assigned
16 to an accepted transaction shall be retained by a facility to
17 verify timely submittal. Once an admission transaction has
18 been completed, all resubmitted claims following prior
19 rejection are subject to receipt no later than 180 days after
20 the admission transaction has been completed.

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

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

agencies and departments shall provide the Illinois Department access to confidential and other information and data necessary to perform eligibility and payment verifications and other 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

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

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

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

1 the recipient's needs, and the requirements and costs for
2 maintaining such equipment. Subject to prior approval, such
3 rules shall enable a recipient to temporarily acquire and use
4 alternative or substitute devices or equipment pending repairs
5 or replacements of any device or equipment previously
6 authorized for such recipient by the Department.
7 Notwithstanding any provision of Section 5-5f to the contrary,
8 the Department may, by rule, exempt certain replacement
9 wheelchair parts from prior approval and, for wheelchairs,
10 wheelchair parts, wheelchair accessories, and related seating
11 and positioning items, determine the wholesale price by
12 methods other than actual acquisition costs.
13 The Department shall require, by rule, all providers of
14 durable medical equipment to be accredited by an accreditation
15 organization approved by the federal Centers for Medicare and
16 Medicaid Services and recognized by the Department in order to
17 bill the Department for providing durable medical equipment to
18 recipients. No later than 15 months after the effective date
19 of the rule adopted pursuant to this paragraph, all providers
20 must meet the accreditation requirement.
21 In order to promote environmental responsibility, meet the
22 needs of recipients and enrollees, and achieve significant
23 cost savings, the Department, or a managed care organization
24 under contract with the Department, may provide recipients or
25 managed care enrollees who have a prescription or Certificate
26 of Medical Necessity access to refurbished durable medical

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

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

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

1 community-based services in circumstances where federal
2 approval has been granted.
3 The Illinois Department shall develop and operate, in
4 cooperation with other State Departments and agencies and in
5 compliance with applicable federal laws and regulations,
6 appropriate and effective systems of health care evaluation
7 and programs for monitoring of utilization of health care
8 services and facilities, as it affects persons eligible for
9 medical assistance under this Code.
10 The Illinois Department shall report annually to the
11 General Assembly, no later than the second Friday in April of
12 1979 and each year thereafter, in regard to:
13 (a) actual statistics and trends in utilization of
14 medical services by public aid recipients;
15 (b) actual statistics and trends in the provision of
16 the various medical services by medical vendors;
17 (c) current rate structures and proposed changes in
18 those rate structures for the various medical vendors; and
19 (d) efforts at utilization review and control by the
20 Illinois Department.
21 The period covered by each report shall be the 3 years
22 ending on the June 30 prior to the report. The report shall
23 include suggested legislation for consideration by the General
24 Assembly. The requirement for reporting to the General
25 Assembly shall be satisfied by filing copies of the report as
26 required by Section 3.1 of the General Assembly Organization

1 Act, and filing such additional copies with the State
2 Government Report Distribution Center for the General Assembly
3 as is required under paragraph (t) of Section 7 of the State
4 Library Act.

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

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

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

1 emergency renal dialysis services covered by the Department.
2 Providers under this Section shall be prior approved and
3 certified by the Department to perform kidney transplantation
4 and the services under this Section shall be limited to
5 services associated with kidney transplantation.
6 Notwithstanding any other provision of this Code to the
7 contrary, on or after July 1, 2015, all FDA approved forms of
8 medication assisted treatment prescribed for the treatment of
9 alcohol dependence or treatment of opioid dependence shall be
10 covered under both fee for service and managed care medical
11 assistance programs for persons who are otherwise eligible for
12 medical assistance under this Article and shall not be subject
13 to any (1) utilization control, other than those established
14 under the American Society of Addiction Medicine patient
15 placement criteria, (2) prior authorization mandate, or (3)
16 lifetime restriction limit mandate.
17 On or after July 1, 2015, opioid antagonists prescribed
18 for the treatment of an opioid overdose, including the
19 medication product, administration devices, and any pharmacy
20 fees or hospital fees related to the dispensing, distribution,
21 and administration of the opioid antagonist, shall be covered
22 under the medical assistance program for persons who are
23 otherwise eligible for medical assistance under this Article.
24 As used in this Section, "opioid antagonist" means a drug that
25 binds to opioid receptors and blocks or inhibits the effect of
26 opioids acting on those receptors, including, but not limited

1 to, naloxone hydrochloride or any other similarly acting drug
2 approved by the U.S. Food and Drug Administration. The
3 Department shall not impose a copayment on the coverage
4 provided for naloxone hydrochloride under the medical
5 assistance program.
6 Upon federal approval, the Department shall provide
7 coverage and reimbursement for all drugs that are approved for
8 marketing by the federal Food and Drug Administration and that
9 are recommended by the federal Public Health Service or the
10 United States Centers for Disease Control and Prevention for
11 pre-exposure prophylaxis and related pre-exposure prophylaxis
12 services, including, but not limited to, HIV and sexually
13 transmitted infection screening, treatment for sexually
14 transmitted infections, medical monitoring, assorted labs, and
15 counseling to reduce the likelihood of HIV infection among
16 individuals who are not infected with HIV but who are at high
17 risk of HIV infection.
18 A federally qualified health center, as defined in Section
19 1905(l)(2)(B) of the federal Social Security Act, shall be
20 reimbursed by the Department in accordance with the federally
21 qualified health center's encounter rate for services provided
22 to medical assistance recipients that are performed by a
23 dental hygienist, as defined under the Illinois Dental
24 Practice Act, working under the general supervision of a
25 dentist and employed by a federally qualified health center.
26 Within 90 days after October 8, 2021 (the effective date

1 of Public Act 102-665), the Department shall seek federal
2 approval of a State Plan amendment to expand coverage for
3 family planning services that includes presumptive eligibility
4 to individuals whose income is at or below 208% of the federal
5 poverty level. Coverage under this Section shall be effective
6 beginning no later than December 1, 2022.

7 Subject to approval by the federal Centers for Medicare
8 and Medicaid Services of a Title XIX State Plan amendment
9 electing the Program of All-Inclusive Care for the Elderly
10 (PACE) as a State Medicaid option, as provided for by Subtitle
11 I (commencing with Section 4801) of Title IV of the Balanced
12 Budget Act of 1997 (Public Law 105-33) and Part 460
13 (commencing with Section 460.2) of Subchapter E of Title 42 of
14 the Code of Federal Regulations, PACE program services shall
15 become a covered benefit of the medical assistance program,
16 subject to criteria established in accordance with all
17 applicable laws.

18 Notwithstanding any other provision of this Code,
19 community-based pediatric palliative care from a trained
20 interdisciplinary team shall be covered under the medical
21 assistance program as provided in Section 15 of the Pediatric
22 Palliative Care Act.

23 Notwithstanding any other provision of this Code, within
24 12 months after June 2, 2022 (the effective date of Public Act
25 102-1037) ~~this amendatory Act of the 102nd General Assembly~~
26 and subject to federal approval, acupuncture services

performed by an acupuncturist licensed under the Acupuncture Practice Act who is acting within the scope of his or her license shall be covered under the medical assistance program. The Department shall apply for any federal waiver or State Plan amendment, if required, to implement this paragraph. The Department may adopt any rules, including standards and criteria, necessary to implement this paragraph.

Notwithstanding any other provision of this Code, the medical assistance program shall, subject to appropriation and federal approval, reimburse hospitals for costs associated with a newborn screening test for the presence of metachromatic leukodystrophy, as required under the Newborn Metabolic Screening Act, at a rate not less than the fee charged by the Department of Public Health. The Department shall seek federal approval before the implementation of the newborn screening test fees by the Department of Public Health.

(Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff. 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22; 102-1038 eff. 1-1-23; revised 2-5-23.)".