



102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB4079

Introduced 5/13/2021, by Rep. Marcus C. Evans, Jr.

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. Provides that, on and after January 1, 2022, targeted dental services that are provided to adults and children under the medical assistance program shall be established and paid at no less than the rates published by the Department of Healthcare and Family Services and effective January 1, 2020 for all local health departments as the fee schedule for children and adult recipients. Sets forth the reimbursement rates for certain anesthesia services.

LRB102 18406 KTG 26333 b

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
16 home, or elsewhere; (6) medical care, or any other type of
17 remedial care furnished by licensed practitioners; (7) home
18 health care services; (8) private duty nursing service; (9)
19 clinic services; (10) dental services, including prevention
20 and treatment of periodontal disease and dental caries disease
21 for pregnant women, provided by an individual licensed to
22 practice dentistry or dental surgery; for purposes of this
23 item (10), "dental services" means diagnostic, preventive, or

1 corrective procedures provided by or under the supervision of
2 a dentist in the practice of his or her profession; (11)
3 physical therapy and related services; (12) prescribed drugs,
4 dentures, and prosthetic devices; and eyeglasses prescribed by
5 a physician skilled in the diseases of the eye, or by an
6 optometrist, whichever the person may select; (13) other
7 diagnostic, screening, preventive, and rehabilitative
8 services, including to ensure that the individual's need for
9 intervention or treatment of mental disorders or substance use
10 disorders or co-occurring mental health and substance use
11 disorders is determined using a uniform screening, assessment,
12 and 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
22 sexual 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. The term "any other type of remedial care"
2 shall include nursing care and nursing home service for
3 persons who rely on treatment by spiritual means alone through
4 prayer for healing.

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

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

17 Notwithstanding any other provision of this Code, the
18 Illinois Department may not require, as a condition of payment
19 for any laboratory test authorized under this Article, that a
20 physician's handwritten signature appear on the laboratory
21 test order form. The Illinois Department may, however, impose
22 other appropriate requirements regarding laboratory test order
23 documentation.

24 Upon receipt of federal approval of an amendment to the
25 Illinois Title XIX State Plan for this purpose, the Department
26 shall authorize the Chicago Public Schools (CPS) to procure a

1 vendor or vendors to manufacture eyeglasses for individuals
2 enrolled in a school within the CPS system. CPS shall ensure
3 that its vendor or vendors are enrolled as providers in the
4 medical assistance program and in any capitated Medicaid
5 managed care entity (MCE) serving individuals enrolled in a
6 school within the CPS system. Under any contract procured
7 under this provision, the vendor or vendors must serve only
8 individuals enrolled in a school within the CPS system. Claims
9 for services provided by CPS's vendor or vendors to recipients
10 of benefits in the medical assistance program under this Code,
11 the Children's Health Insurance Program, or the Covering ALL
12 KIDS Health Insurance Program shall be submitted to the
13 Department or the MCE in which the individual is enrolled for
14 payment and shall be reimbursed at the Department's or the
15 MCE's established rates or rate methodologies for eyeglasses.

16 On and after July 1, 2012, the Department of Healthcare
17 and Family Services may provide the following services to
18 persons eligible for assistance under this Article who are
19 participating in education, training or employment programs
20 operated by the Department of Human Services as successor to
21 the Department of Public Aid:

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

24 (2) eyeglasses prescribed by a physician skilled in
25 the diseases of the eye, or by an optometrist, whichever
26 the person may select.

1 On and after July 1, 2018, the Department of Healthcare
2 and Family Services shall provide dental services to any adult
3 who is otherwise eligible for assistance under the medical
4 assistance program. As used in this paragraph, "dental
5 services" means diagnostic, preventative, restorative, or
6 corrective procedures, including procedures and services for
7 the prevention and treatment of periodontal disease and dental
8 caries disease, provided by an individual who is licensed to
9 practice dentistry or dental surgery or who is under the
10 supervision of a dentist in the practice of his or her
11 profession.

12 On and after July 1, 2018, targeted dental services, as
13 set forth in Exhibit D of the Consent Decree entered by the
14 United States District Court for the Northern District of
15 Illinois, Eastern Division, in the matter of Memisovski v.
16 Maram, Case No. 92 C 1982, that are provided to adults under
17 the medical assistance program shall be established at no less
18 than the rates set forth in the "New Rate" column in Exhibit D
19 of the Consent Decree for targeted dental services that are
20 provided to persons under the age of 18 under the medical
21 assistance program.

22 On and after January 1, 2022, targeted dental services
23 that are provided to adults and children under the medical
24 assistance program shall be established and paid at no less
25 than the rates published by the Department and effective
26 January 1, 2020 for all local health departments as the fee

1 schedule for children and adult recipients. In addition, in
2 order to address the growing crisis in the need for anesthesia
3 related services for children and adults with disabilities,
4 the following anesthesia related codes shall be reimbursed as
5 follows:

6 (i) D9230 Inhalation of nitrous oxide, \$70.

7 (ii) D9248 Non-intravenous conscious sedation, \$150.

8 (iii) D9239 Intravenous moderate sedation, first 15
9 minutes, \$181.

10 (iv) D9243 Intravenous moderate sedation, each
11 additional 15 minutes, \$181.

12 (v) D9222 Deep sedation, first 15 minutes, \$214.

13 (vi) D9223 Deep sedation, each additional 15 minutes,
14 \$214.

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

1 dental services rendered under this provision.

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

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

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

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

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

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

1 (D) A comprehensive ultrasound screening and MRI of an
2 entire breast or breasts if a mammogram demonstrates
3 heterogeneous or dense breast tissue or when medically
4 necessary as determined by a physician licensed to
5 practice medicine in all of its branches.

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

9 (F) A diagnostic mammogram when medically necessary,
10 as determined by a physician licensed to practice medicine
11 in all its branches, advanced practice registered nurse,
12 or physician assistant.

13 The Department shall not impose a deductible, coinsurance,
14 copayment, or any other cost-sharing requirement on the
15 coverage provided under this paragraph; except that this
16 sentence does not apply to coverage of diagnostic mammograms
17 to the extent such coverage would disqualify a high-deductible
18 health plan from eligibility for a health savings account
19 pursuant to Section 223 of the Internal Revenue Code (26
20 U.S.C. 223).

21 All screenings shall include a physical breast exam,
22 instruction on self-examination and information regarding the
23 frequency of self-examination and its value as a preventative
24 tool.

25 For purposes of this Section:

26 "Diagnostic mammogram" means a mammogram obtained using

1 diagnostic mammography.

2 "Diagnostic mammography" means a method of screening that
3 is designed to evaluate an abnormality in a breast, including
4 an abnormality seen or suspected on a screening mammogram or a
5 subjective or objective abnormality otherwise detected in the
6 breast.

7 "Low-dose mammography" means the x-ray examination of the
8 breast using equipment dedicated specifically for mammography,
9 including the x-ray tube, filter, compression device, and
10 image receptor, with an average radiation exposure delivery of
11 less than one rad per breast for 2 views of an average size
12 breast. The term also includes digital mammography and
13 includes breast tomosynthesis.

14 "Breast tomosynthesis" means a radiologic procedure that
15 involves the acquisition of projection images over the
16 stationary breast to produce cross-sectional digital
17 three-dimensional images of the breast.

18 If, at any time, the Secretary of the United States
19 Department of Health and Human Services, or its successor
20 agency, promulgates rules or regulations to be published in
21 the Federal Register or publishes a comment in the Federal
22 Register or issues an opinion, guidance, or other action that
23 would require the State, pursuant to any provision of the
24 Patient Protection and Affordable Care Act (Public Law
25 111-148), including, but not limited to, 42 U.S.C.
26 18031(d)(3)(B) or any successor provision, to defray the cost

1 of any coverage for breast tomosynthesis outlined in this
2 paragraph, then the requirement that an insurer cover breast
3 tomosynthesis is inoperative other than any such coverage
4 authorized under Section 1902 of the Social Security Act, 42
5 U.S.C. 1396a, and the State shall not assume any obligation
6 for the cost of coverage for breast tomosynthesis set forth in
7 this paragraph.

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

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

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

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

1 cancer treatment quality program.

2 The Department shall convene an expert panel, including
3 representatives of hospitals, free-standing breast cancer
4 treatment centers, breast cancer quality organizations, and
5 doctors, including breast surgeons, reconstructive breast
6 surgeons, oncologists, and primary care providers to establish
7 quality standards for breast cancer treatment.

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

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

24 The Department shall establish a performance goal for
25 primary care providers with respect to their female patients
26 over age 40 receiving an annual mammogram. This performance

1 goal shall be used to provide additional reimbursement in the
2 form of a quality performance bonus to primary care providers
3 who meet that goal.

4 The Department shall devise a means of case-managing or
5 patient navigation for beneficiaries diagnosed with breast
6 cancer. This program shall initially operate as a pilot
7 program in areas of the State with the highest incidence of
8 mortality related to breast cancer. At least one pilot program
9 site shall be in the metropolitan Chicago area and at least one
10 site shall be outside the metropolitan Chicago area. On or
11 after July 1, 2016, the pilot program shall be expanded to
12 include one site in western Illinois, one site in southern
13 Illinois, one site in central Illinois, and 4 sites within
14 metropolitan Chicago. An evaluation of the pilot program shall
15 be carried out measuring health outcomes and cost of care for
16 those served by the pilot program compared to similarly
17 situated patients who are not served by the pilot program.

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

26 Any medical or health care provider shall immediately

1 recommend, to any pregnant woman who is being provided
2 prenatal services and is suspected of having a substance use
3 disorder as defined in the Substance Use Disorder Act,
4 referral to a local substance use disorder treatment program
5 licensed by the Department of Human Services or to a licensed
6 hospital which provides substance abuse treatment services.
7 The Department of Healthcare and Family Services shall assure
8 coverage for the cost of treatment of the drug abuse or
9 addiction for pregnant recipients in accordance with the
10 Illinois Medicaid Program in conjunction with the Department
11 of Human Services.

12 All medical providers providing medical assistance to
13 pregnant women under this Code shall receive information from
14 the Department on the availability of services under any
15 program providing case management services for addicted women,
16 including information on appropriate referrals for other
17 social services that may be needed by addicted women in
18 addition to treatment for addiction.

19 The Illinois Department, in cooperation with the
20 Departments of Human Services (as successor to the Department
21 of Alcoholism and Substance Abuse) and Public Health, through
22 a public awareness campaign, may provide information
23 concerning treatment for alcoholism and drug abuse and
24 addiction, prenatal health care, and other pertinent programs
25 directed at reducing the number of drug-affected infants born
26 to recipients of medical assistance.

1 Neither the Department of Healthcare and Family Services
2 nor the Department of Human Services shall sanction the
3 recipient solely on the basis of her substance abuse.

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

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

23 The sponsor must negotiate formal written contracts with
24 medical providers for physician services, inpatient and
25 outpatient hospital care, home health services, treatment for
26 alcoholism and substance abuse, and other services determined

1 necessary by the Illinois Department by rule for delivery by
2 Partnerships. Physician services must include prenatal and
3 obstetrical care. The Illinois Department shall reimburse
4 medical services delivered by Partnership providers to clients
5 in target areas according to provisions of this Article and
6 the Illinois Health Finance Reform Act, except that:

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

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

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

19 Medical providers shall be required to meet certain
20 qualifications to participate in Partnerships to ensure the
21 delivery of high quality medical services. These
22 qualifications shall be determined by rule of the Illinois
23 Department and may be higher than qualifications for
24 participation in the medical assistance program. Partnership
25 sponsors may prescribe reasonable additional qualifications
26 for participation by medical providers, only with the prior

1 written approval of the Illinois Department.

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

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

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

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

1 updated no less frequently than every 30 days as required by
2 Section 5-5.12.

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

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

25 The Illinois Department shall require all dispensers of
26 medical services, other than an individual practitioner or

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

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

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

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

1 the vendor.

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

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

24 To be eligible for payment consideration, a vendor's
25 payment claim or bill, either as an initial claim or as a
26 resubmitted claim following prior rejection, must be received

1 by the Illinois Department, or its fiscal intermediary, no
2 later than 180 days after the latest date on the claim on which
3 medical goods or services were provided, with the following
4 exceptions:

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

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

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

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

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

1 adjudication by the primary payer.

2 In the case of long term care facilities, within 45
3 calendar days of receipt by the facility of required
4 prescreening information, new admissions with associated
5 admission documents shall be submitted through the Medical
6 Electronic Data Interchange (MEDI) or the Recipient
7 Eligibility Verification (REV) System or shall be submitted
8 directly to the Department of Human Services using required
9 admission forms. Effective September 1, 2014, admission
10 documents, including all prescreening information, must be
11 submitted through MEDI or REV. Confirmation numbers assigned
12 to an accepted transaction shall be retained by a facility to
13 verify timely submittal. Once an admission transaction has
14 been completed, all resubmitted claims following prior
15 rejection are subject to receipt no later than 180 days after
16 the 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
25 necessary to perform eligibility and payment verifications and
26 other Illinois Department functions. This includes, but is not

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

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

26 Beginning in fiscal year 2013, the Illinois Department

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

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

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

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

17 In order to promote environmental responsibility, meet the
18 needs of recipients and enrollees, and achieve significant
19 cost savings, the Department, or a managed care organization
20 under contract with the Department, may provide recipients or
21 managed care enrollees who have a prescription or Certificate
22 of Medical Necessity access to refurbished durable medical
23 equipment under this Section (excluding prosthetic and
24 orthotic devices as defined in the Orthotics, Prosthetics, and
25 Pedorthics Practice Act and complex rehabilitation technology
26 products and associated services) through the State's

1 assistive technology program's reutilization program, using
2 staff with the Assistive Technology Professional (ATP)
3 Certification if the refurbished durable medical equipment:
4 (i) is available; (ii) is less expensive, including shipping
5 costs, than new durable medical equipment of the same type;
6 (iii) is able to withstand at least 3 years of use; (iv) is
7 cleaned, disinfected, sterilized, and safe in accordance with
8 federal Food and Drug Administration regulations and guidance
9 governing the reprocessing of medical devices in health care
10 settings; and (v) equally meets the needs of the recipient or
11 enrollee. The reutilization program shall confirm that the
12 recipient or enrollee is not already in receipt of same or
13 similar equipment from another service provider, and that the
14 refurbished durable medical equipment equally meets the needs
15 of the recipient or enrollee. Nothing in this paragraph shall
16 be construed to limit recipient or enrollee choice to obtain
17 new durable medical equipment or place any additional prior
18 authorization conditions on enrollees of managed care
19 organizations.

20 The Department shall execute, relative to the nursing home
21 prescreening project, written inter-agency agreements with the
22 Department of Human Services and the Department on Aging, to
23 effect the following: (i) intake procedures and common
24 eligibility criteria for those persons who are receiving
25 non-institutional services; and (ii) the establishment and
26 development of non-institutional services in areas of the

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

25 The Illinois Department shall develop and operate, in
26 cooperation with other State Departments and agencies and in

1 compliance with applicable federal laws and regulations,
2 appropriate and effective systems of health care evaluation
3 and programs for monitoring of utilization of health care
4 services and facilities, as it affects persons eligible for
5 medical assistance under this Code.

6 The Illinois Department shall report annually to the
7 General Assembly, no later than the second Friday in April of
8 1979 and each year thereafter, in regard to:

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

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

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

15 (d) efforts at utilization review and control by the
16 Illinois Department.

17 The period covered by each report shall be the 3 years
18 ending on the June 30 prior to the report. The report shall
19 include suggested legislation for consideration by the General
20 Assembly. The requirement for reporting to the General
21 Assembly shall be satisfied by filing copies of the report as
22 required by Section 3.1 of the General Assembly Organization
23 Act, and filing such additional copies with the State
24 Government Report Distribution Center for the General Assembly
25 as is required under paragraph (t) of Section 7 of the State
26 Library Act.

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

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

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

1 services associated with kidney transplantation.

2 Notwithstanding any other provision of this Code to the
3 contrary, on or after July 1, 2015, all FDA approved forms of
4 medication assisted treatment prescribed for the treatment of
5 alcohol dependence or treatment of opioid dependence shall be
6 covered under both fee for service and managed care medical
7 assistance programs for persons who are otherwise eligible for
8 medical assistance under this Article and shall not be subject
9 to any (1) utilization control, other than those established
10 under the American Society of Addiction Medicine patient
11 placement criteria, (2) prior authorization mandate, or (3)
12 lifetime restriction limit mandate.

13 On or after July 1, 2015, opioid antagonists prescribed
14 for the treatment of an opioid overdose, including the
15 medication product, administration devices, and any pharmacy
16 fees related to the dispensing and administration of the
17 opioid antagonist, shall be covered under the medical
18 assistance program for persons who are otherwise eligible for
19 medical assistance under this Article. As used in this
20 Section, "opioid antagonist" means a drug that binds to opioid
21 receptors and blocks or inhibits the effect of opioids acting
22 on those receptors, including, but not limited to, naloxone
23 hydrochloride or any other similarly acting drug approved by
24 the U.S. Food and Drug Administration.

25 Upon federal approval, the Department shall provide
26 coverage and reimbursement for all drugs that are approved for

1 marketing by the federal Food and Drug Administration and that
2 are recommended by the federal Public Health Service or the
3 United States Centers for Disease Control and Prevention for
4 pre-exposure prophylaxis and related pre-exposure prophylaxis
5 services, including, but not limited to, HIV and sexually
6 transmitted infection screening, treatment for sexually
7 transmitted infections, medical monitoring, assorted labs, and
8 counseling to reduce the likelihood of HIV infection among
9 individuals who are not infected with HIV but who are at high
10 risk of HIV infection.

11 A federally qualified health center, as defined in Section
12 1905(1)(2)(B) of the federal Social Security Act, shall be
13 reimbursed by the Department in accordance with the federally
14 qualified health center's encounter rate for services provided
15 to medical assistance recipients that are performed by a
16 dental hygienist, as defined under the Illinois Dental
17 Practice Act, working under the general supervision of a
18 dentist and employed by a federally qualified health center.

19 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
20 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
21 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
22 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
23 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
24 1-1-20; revised 9-18-19.)