AN ACT concerning public aid.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Public Aid Code is amended by changing Section 5-5 as follows:

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this 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

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

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

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

(2) eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever 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 Notwithstanding any other provision of this Code and
23 subject to federal approval, the Department may adopt rules to
24 allow a dentist who is volunteering his or her service at no
25 cost to render dental services through an enrolled
26 not-for-profit health clinic without the dentist personally

1 enrolling as a participating provider in the medical
2 assistance program. A not-for-profit health clinic shall
3 include a public health clinic or Federally Qualified Health
4 Center or other enrolled provider, as determined by the
5 Department, through which dental services covered under this
6 Section are performed. The Department shall establish a
7 process for payment of claims for reimbursement for covered
8 dental services rendered under this provision.

9 On and after January 1, 2022, the Department of Healthcare
10 and Family Services shall administer and regulate a
11 school-based dental program that allows for the out-of-office
12 delivery of preventative dental services in a school setting
13 to children under 19 years of age. The Department shall
14 establish, by rule, guidelines for participation by providers
15 and set requirements for follow-up referral care based on the
16 requirements established in the Dental Office Reference Manual
17 published by the Department that establishes the requirements
18 for dentists participating in the All Kids Dental School
19 Program. Every effort shall be made by the Department when
20 developing the program requirements to consider the different
21 geographic differences of both urban and rural areas of the
22 State for initial treatment and necessary follow-up care. No
23 provider shall be charged a fee by any unit of local government
24 to participate in the school-based dental program administered
25 by the Department. Nothing in this paragraph shall be
26 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 women 35 years of age or older who are eligible for medical assistance under this Article, as follows:

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

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

(C) A mammogram at the age and intervals considered medically necessary by the woman's health care provider

for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

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

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

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

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

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

tool.

For purposes of this Section:

"Diagnostic mammogram" means a mammogram obtained using diagnostic mammography.

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

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

"Breast tomosynthesis" means a radiologic procedure that 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

1 Patient Protection and Affordable Care Act (Public Law
2 111-148), including, but not limited to, 42 U.S.C.
3 18031(d)(3)(B) or any successor provision, to defray the cost
4 of any coverage for breast tomosynthesis outlined in this
5 paragraph, then the requirement that an insurer cover breast
6 tomosynthesis is inoperative other than any such coverage
7 authorized under Section 1902 of the Social Security Act, 42
8 U.S.C. 1396a, and the State shall not assume any obligation
9 for the cost of coverage for breast tomosynthesis set forth in
10 this paragraph.

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

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

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

25 On and after January 1, 2017, providers participating in a
26 breast cancer treatment quality improvement program approved

1 by the Department shall be reimbursed for breast cancer
2 treatment at a rate that is no lower than 95% of the Medicare
3 program's rates for the data elements included in the breast
4 cancer treatment quality program.

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

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

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

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

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

21 The Department shall require all networks of care to
22 develop a means either internally or by contract with experts
23 in navigation and community outreach to navigate cancer
24 patients to comprehensive care in a timely fashion. The
25 Department shall require all networks of care to include
26 access for patients diagnosed with cancer to at least one

1 academic commission on cancer-accredited cancer program as an
2 in-network covered benefit.

3 Any medical or health care provider shall immediately
4 recommend, to any pregnant woman 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 women under this Code shall receive information from
17 the Department on the availability of services under any
18 program providing case management services for addicted women,
19 including information on appropriate referrals for other
20 social services that may be needed by addicted women in
21 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

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

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

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

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

26 The sponsor must negotiate formal written contracts with

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

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

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

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

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

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

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

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

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

1 technology platforms are implemented.

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

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

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

1 penalty.
2 The Department has the discretion to limit the conditional
3 enrollment period for vendors based upon category of risk of
4 the vendor.
5 Prior to enrollment and during the conditional enrollment
6 period in the medical assistance program, all vendors shall be
7 subject to enhanced oversight, screening, and review based on
8 the risk of fraud, waste, and abuse that is posed by the
9 category of risk of the vendor. The Illinois Department shall
10 establish the procedures for oversight, screening, and review,
11 which may include, but need not be limited to: criminal and
12 financial background checks; fingerprinting; license,
13 certification, and authorization verifications; unscheduled or
14 unannounced site visits; database checks; prepayment audit
15 reviews; audits; payment caps; payment suspensions; and other
16 screening as required by federal or State law.
17 The Department shall define or specify the following: (i)
18 by provider notice, the "category of risk of the vendor" for
19 each type of vendor, which shall take into account the level of
20 screening applicable to a particular category of vendor under
21 federal law and regulations; (ii) by rule or provider notice,
22 the maximum length of the conditional enrollment period for
23 each category of risk of the vendor; and (iii) by rule, the
24 hearing rights, if any, afforded to a vendor in each category
25 of risk of the vendor that is terminated or disenrolled during
26 the conditional enrollment period.

1 To be eligible for payment consideration, a vendor's
2 payment claim or bill, either as an initial claim or as a
3 resubmitted claim following prior rejection, must be received
4 by the Illinois Department, or its fiscal intermediary, no
5 later than 180 days after the latest date on the claim on which
6 medical goods or services were provided, with the following
7 exceptions:
8 (1) In the case of a provider whose enrollment is in
9 process by the Illinois Department, the 180-day period
10 shall not begin until the date on the written notice from
11 the Illinois Department that the provider enrollment is
12 complete.
13 (2) In the case of errors attributable to the Illinois
14 Department or any of its claims processing intermediaries
15 which result in an inability to receive, process, or
16 adjudicate a claim, the 180-day period shall not begin
17 until the provider has been notified of the error.
18 (3) In the case of a provider for whom the Illinois
19 Department initiates the monthly billing process.
20 (4) In the case of a provider operated by a unit of
21 local government with a population exceeding 3,000,000
22 when local government funds finance federal participation
23 for claims payments.
24 For claims for services rendered during a period for which
25 a recipient received retroactive eligibility, claims must be
26 filed within 180 days after the Department determines the

applicant is eligible. For claims for which the Illinois Department is not the primary payer, claims must be submitted to the Illinois Department within 180 days after the final adjudication by the primary payer.

In the case of long term care facilities, within 45 calendar days of receipt by the facility of required prescreening information, new admissions with associated admission documents shall be submitted through the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System or shall be submitted directly to the Department of Human Services using required admission forms. Effective September 1, 2014, admission documents, including all prescreening information, must be submitted through MEDI or REV. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.

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

To the extent consistent with applicable information and privacy, security, and disclosure laws, State and federal agencies and departments shall provide the Illinois Department

1 access to confidential and other information and data
2 necessary to perform eligibility and payment verifications and
3 other Illinois Department functions. This includes, but is not
4 limited to: information pertaining to licensure;
5 certification; earnings; immigration status; citizenship; wage
6 reporting; unearned and earned income; pension income;
7 employment; supplemental security income; social security
8 numbers; National Provider Identifier (NPI) numbers; the
9 National Practitioner Data Bank (NPDB); program and agency
10 exclusions; taxpayer identification numbers; tax delinquency;
11 corporate information; and death records.

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

1 Human Services; and the Department of Financial and
2 Professional Regulation.
3 Beginning in fiscal year 2013, the Illinois Department
4 shall set forth a request for information to identify the
5 benefits of a pre-payment, post-adjudication, and post-edit
6 claims system with the goals of streamlining claims processing
7 and provider reimbursement, reducing the number of pending or
8 rejected claims, and helping to ensure a more transparent
9 adjudication process through the utilization of: (i) provider
10 data verification and provider screening technology; and (ii)
11 clinical code editing; and (iii) pre-pay, pre- or
12 post-adjudicated predictive modeling with an integrated case
13 management system with link analysis. Such a request for
14 information shall not be considered as a request for proposal
15 or as an obligation on the part of the Illinois Department to
16 take any action or acquire any products or services.
17 The Illinois Department shall establish policies,
18 procedures, standards and criteria by rule for the
19 acquisition, repair and replacement of orthotic and prosthetic
20 devices and durable medical equipment. Such rules shall
21 provide, but not be limited to, the following services: (1)
22 immediate repair or replacement of such devices by recipients;
23 and (2) rental, lease, purchase or lease-purchase of durable
24 medical equipment in a cost-effective manner, taking into
25 consideration the recipient's medical prognosis, the extent of
26 the recipient's needs, and the requirements and costs for

maintaining such equipment. Subject to prior approval, such rules shall enable a recipient to temporarily acquire and use alternative or substitute devices or equipment pending repairs or replacements of any device or equipment previously authorized for such recipient by the Department. Notwithstanding any provision of Section 5-5f to the contrary, the Department may, by rule, exempt certain replacement wheelchair parts from prior approval and, for wheelchairs, wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

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

In order to promote environmental responsibility, meet the needs of recipients and enrollees, and achieve significant cost savings, the Department, or a managed care organization under contract with the Department, may provide recipients or managed care enrollees who have a prescription or Certificate of Medical Necessity access to refurbished durable medical equipment under this Section (excluding prosthetic and

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

23 The Department shall execute, relative to the nursing home
24 prescreening project, written inter-agency agreements with the
25 Department of Human Services and the Department on Aging, to
26 effect the following: (i) intake procedures and common

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

approval has been granted.

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

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

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

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

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

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

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act, and filing such additional copies with the State

Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

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

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

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

1 Providers under this Section shall be prior approved and
2 certified by the Department to perform kidney transplantation
3 and the services under this Section shall be limited to
4 services associated with kidney transplantation.

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

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

1 the U.S. Food and Drug Administration.
2 Upon federal approval, the Department shall provide
3 coverage and reimbursement for all drugs that are approved for
4 marketing by the federal Food and Drug Administration and that
5 are recommended by the federal Public Health Service or the
6 United States Centers for Disease Control and Prevention for
7 pre-exposure prophylaxis and related pre-exposure prophylaxis
8 services, including, but not limited to, HIV and sexually
9 transmitted infection screening, treatment for sexually
10 transmitted infections, medical monitoring, assorted labs, and
11 counseling to reduce the likelihood of HIV infection among
12 individuals who are not infected with HIV but who are at high
13 risk of HIV infection.
14 A federally qualified health center, as defined in Section
15 1905(l)(2)(B) of the federal Social Security Act, shall be
16 reimbursed by the Department in accordance with the federally
17 qualified health center's encounter rate for services provided
18 to medical assistance recipients that are performed by a
19 dental hygienist, as defined under the Illinois Dental
20 Practice Act, working under the general supervision of a
21 dentist and employed by a federally qualified health center.
22 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
23 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
24 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
25 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
26 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.

1 1-1-20; revised 9-18-19.)

2 Section 99. Effective date. This Act takes effect January
3 1, 2022.