Rep. Greg Harris

Filed: 5/29/2021

1 AMENDMENT TO SENATE BILL 2294

2 AMENDMENT NO. ______. Amend Senate Bill 2294 by replacing
3 everything after the enacting clause with the following:

4 "Article 3.

5 Section 3-1. Short title. This Act may be cited as the
6 Illinois Certified Community Behavioral Health Clinics Act.

7 Section 3-5. Certified Community Behavioral Health Clinic
8 program. The Department of Healthcare and Family Services, in
9 collaboration with the Department of Human Services and with
10 meaningful input from customers and key behavioral health
11 stakeholders, shall develop a Comprehensive Statewide
12 Behavioral Health Strategy and shall submit this Strategy to
13 the Governor and General Assembly no later than July 1, 2022.
14 The Strategy shall address key components of current and past
15 legislation as well as current initiatives related to

1 behavioral health services in order to develop a cohesive
2 behavioral health system that reduces the administrative
3 burden for customers and providers and includes: (i)
4 comprehensive home and community-based services; (ii)
5 integrated mental health, substance use disorder, and physical
6 health services, and social determinants of health; and (iii)
7 innovative payment models that support providers in offering
8 integrated services that are clinically effective and fiscally
9 supported. The Strategy shall consolidate required pilots and
10 initiatives into a cohesive behavioral health system designed
11 to serve both adults and children in the least restrictive
12 setting, as early as possible, once behavioral health needs
13 have been identified, and through evidence-informed practices
14 identified by the Substance Abuse and Mental Health Services
15 Administration (SAMHSA) and other national experts. The
16 Strategy shall take into consideration initiatives such as the
17 Healthcare Transformation Collaboratives program; integrated
18 health homes; services offered under federal Medicaid waiver
19 authorities, including Sections 1915(i) and 1115 of the Social
20 Security Act; requirements for certified community behavioral
21 health centers; enhanced team-based services; housing and
22 employment supports; and other initiatives identified by
23 customers and stakeholders. The Strategy shall also identify
24 the proper capacity for residential and institutional services
25 while emphasizing serving customers in the community.
26 As part of the Strategy development process, by January 1,

1 2022 the Department of Healthcare and Family Services shall
2 establish a program for the implementation of certified
3 community behavioral health clinics. Behavioral health
4 services providers that received federal grant funding from
5 SAMHSA for the implementation of certified community
6 behavioral health clinics prior to July 1, 2021 shall be
7 eligible to participate in the program established in
8 accordance with this Section.

9 Article 5.

10 Section 5-5. The Illinois Public Aid Code is amended by
11 changing Section 5-5f and by adding Section 5-41 as follows:

12 (305 ILCS 5/5-5f)
13 Sec. 5-5f. Elimination and limitations of medical
14 assistance services. Notwithstanding any other provision of
15 this Code to the contrary, on and after July 1, 2012:
16 (a) The following services shall no longer be a
17 covered service available under this Code: group
18 psychotherapy for residents of any facility licensed under
19 the Nursing Home Care Act or the Specialized Mental Health
20 Rehabilitation Act of 2013; and adult chiropractic
21 services.
22 (b) The Department shall place the following
23 limitations on services: (i) the Department shall limit

1 adult eyeglasses to one pair every 2 years; however, the
2 limitation does not apply to an individual who needs
3 different eyeglasses following a surgical procedure such
4 as cataract surgery; (ii) the Department shall set an
5 annual limit of a maximum of 20 visits for each of the
6 following services: adult speech, hearing, and language
7 therapy services, adult occupational therapy services, and
8 physical therapy services; on or after October 1, 2014,
9 the annual maximum limit of 20 visits shall expire but the
10 Department may require prior approval for all individuals
11 for speech, hearing, and language therapy services,
12 occupational therapy services, and physical therapy
13 services; (iii) the Department shall limit adult podiatry
14 services to individuals with diabetes; on or after October
15 1, 2014, podiatry services shall not be limited to
16 individuals with diabetes; (iv) the Department shall pay
17 for caesarean sections at the normal vaginal delivery rate
18 unless a caesarean section was medically necessary; (v)
19 the Department shall limit adult dental services to
20 emergencies; beginning July 1, 2013, the Department shall
21 ensure that the following conditions are recognized as
22 emergencies: (A) dental services necessary for an
23 individual in order for the individual to be cleared for a
24 medical procedure, such as a transplant; (B) extractions
25 and dentures necessary for a diabetic to receive proper
26 nutrition; (C) extractions and dentures necessary as a

1 result of cancer treatment; and (D) dental services
2 necessary for the health of a pregnant woman prior to
3 delivery of her baby; on or after July 1, 2014, adult
4 dental services shall no longer be limited to emergencies,
5 and dental services necessary for the health of a pregnant
6 woman prior to delivery of her baby shall continue to be
7 covered; and (vi) effective July 1, 2012 through June 30,
8 2021, the Department shall place limitations and require
9 concurrent review on every inpatient detoxification stay
10 to prevent repeat admissions to any hospital for
11 detoxification within 60 days of a previous inpatient
12 detoxification stay. The Department shall convene a
13 workgroup of hospitals, substance abuse providers, care
14 coordination entities, managed care plans, and other
15 stakeholders to develop recommendations for quality
16 standards, diversion to other settings, and admission
17 criteria for patients who need inpatient detoxification,
18 which shall be published on the Department's website no
19 later than September 1, 2013.
20 (c) The Department shall require prior approval of the
21 following services: wheelchair repairs costing more than
22 $400, coronary artery bypass graft, and bariatric surgery
23 consistent with Medicare standards concerning patient
24 responsibility. Wheelchair repair prior approval requests
25 shall be adjudicated within one business day of receipt of
26 complete supporting documentation. Providers may not break

wheelchair repairs into separate claims for purposes of staying under the $400 threshold for requiring prior approval. The wholesale price of manual and power wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

(d) The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a minimum, $40,000,000.

(e) The Department shall establish utilization controls for the hospice program such that it shall not pay for other care services when an individual is in hospice.

1 (f) For home health services, the Department shall
2 require Medicare certification of providers participating
3 in the program and implement the Medicare face-to-face
4 encounter rule. The Department shall require providers to
5 implement auditable electronic service verification based
6 on global positioning systems or other cost-effective
7 technology.

8 (g) For the Home Services Program operated by the
9 Department of Human Services and the Community Care
10 Program operated by the Department on Aging, the
11 Department of Human Services, in cooperation with the
12 Department on Aging, shall implement an electronic service
13 verification based on global positioning systems or other
14 cost-effective technology.

15 (h) Effective with inpatient hospital admissions on or
16 after July 1, 2012, the Department shall reduce the
17 payment for a claim that indicates the occurrence of a
18 provider-preventable condition during the admission as
19 specified by the Department in rules. The Department shall
20 not pay for services related to an other
21 provider-preventable condition.

22 As used in this subsection (h):

23 "Provider-preventable condition" means a health care
24 acquired condition as defined under the federal Medicaid
25 regulation found at 42 CFR 447.26 or an other
26 provider-preventable condition.

1 "Other provider-preventable condition" means a wrong
2 surgical or other invasive procedure performed on a
3 patient, a surgical or other invasive procedure performed
4 on the wrong body part, or a surgical procedure or other
5 invasive procedure performed on the wrong patient.
6 (i) The Department shall implement cost savings
7 initiatives for advanced imaging services, cardiac imaging
8 services, pain management services, and back surgery. Such
9 initiatives shall be designed to achieve annual costs
10 savings.
11 (j) The Department shall ensure that beneficiaries
12 with a diagnosis of epilepsy or seizure disorder in
13 Department records will not require prior approval for
14 anticonvulsants.
15 (Source: P.A. 100-135, eff. 8-18-17; 101-209, eff. 8-5-19.)

16 (305 ILCS 5/5-41 new)
17 Sec. 5-41. Inpatient hospitalization for opioid-related
18 overdose or withdrawal patients. Due to the disproportionately
19 high opioid-related fatality rates among African Americans in
20 under-resourced communities in Illinois, the lack of community
21 resources, the comorbidities experienced by these patients,
22 and the high rate of hospital inpatient recidivism associated
23 with this population when improperly treated, the Department
24 shall ensure that every patient experiencing an opioid-related
25 overdose or withdrawal is admitted on an inpatient status when

1 medically necessary, as determined by either the patient's
2 primary care physician or the physician or other practitioner
3 responsible for the patient's care at the hospital to which
4 the patient presents using criteria established by the
5 American Society of Addiction Medicine. This requirement for
6 inpatient hospital admission shall apply to all patients
7 eligible for medical assistance regardless of whether they are
8 enrolled in the fee-for-service medical assistance program or
9 with a Medicaid managed care organization. If a patient is
10 admitted on an inpatient status, the Department shall ensure
11 that the hospital provider is reimbursed accordingly. If it is
12 determined by a patient's physician, or any other practitioner
13 responsible for the patient's care at the hospital to which
14 the patient presents, that the patient does not meet medical
15 necessity criteria for inpatient admission, then the patient
16 may be treated via observation and the provider shall seek
17 reimbursement accordingly. Nothing in this Section shall
18 diminish the requirements of a provider to document medical
19 necessity in the patient's record.

20 Article 10.

21 Section 10-5. The Illinois Public Aid Code is amended by
22 changing Section 5-8 as follows:

23 (305 ILCS 5/5-8) (from Ch. 23, par. 5-8)

1 Sec. 5-8. Practitioners. In supplying medical assistance,
2 the Illinois Department may provide for the legally authorized
3 services of (i) persons licensed under the Medical Practice
4 Act of 1987, as amended, except as hereafter in this Section
5 stated, whether under a general or limited license, (ii)
6 persons licensed under the Nurse Practice Act as advanced
7 practice registered nurses, regardless of whether or not the
8 persons have written collaborative agreements, (iii) persons
9 licensed or registered under other laws of this State to
10 provide dental, medical, pharmaceutical, optometric,
11 podiatric, or nursing services, or other remedial care
12 recognized under State law, (iv) persons licensed under other
13 laws of this State as a clinical social worker, and (v) persons
14 licensed under other laws of this State as physician
15 assistants. The Department shall adopt rules, no later than 90
16 days after January 1, 2017 (the effective date of Public Act
17 99-621), for the legally authorized services of persons
18 licensed under other laws of this State as a clinical social
19 worker. The Department shall provide for the legally
20 authorized services of persons licensed under the Professional
21 Counselor and Clinical Professional Counselor Licensing and
22 Practice Act as clinical professional counselors and for the
23 legally authorized services of persons licensed under the
24 Marriage and Family Therapy Licensing Act as marriage and
25 family therapists. The utilization of the services of persons
26 engaged in the treatment or care of the sick, which persons are

not required to be licensed or registered under the laws of this State, is not prohibited by this Section.
(Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17; 100-453, eff. 8-25-17; 100-513, eff. 1-1-18; 100-538, eff. 1-1-18; 100-863, eff. 8-14-18.)

Article 15.

Section 15-5. The Department of Healthcare and Family Services Law of the Civil Administrative Code of Illinois is amended by adding Section 2205-35 as follows:

(20 ILCS 2205/2205-35 new)

Sec. 2205-35. Certified veteran support specialists. The Department of Healthcare and Family Services shall recognize veteran support specialists who are certified by, and in good standing with, the Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc. as mental health professionals as defined in the Illinois Title XIX State Plan and in 89 Ill. Adm. Code 140.453.

Article 20.

Section 20-5. The Illinois Public Aid Code is amended by adding Section 5-5.4k as follows:

1 (305 ILCS 5/5-5.4k new)
2 Sec. 5-5.4k. Payments for long-acting injectable
3 medications for mental health or substance use disorders.
4 Notwithstanding any other provision of this Code, for dates of
5 service on and after January 1, 2022, the medical assistance
6 program shall separately reimburse at the prevailing fee
7 schedule long-acting injectable medications administered for
8 mental health or substance use disorders in an inpatient
9 hospital setting and which are compliant with the prior
10 authorization requirements of this Section. The Department, in
11 consultation with a statewide association representing a
12 majority of hospitals and managed care organizations, shall
13 implement, by rule, reimbursement policy and prior
14 authorization criteria for the use of long-acting injectable
15 medications administered in an inpatient hospital setting for
16 the treatment of mental health or substance use disorders.

17 Article 25.

18 Section 25-3. The Illinois Administrative Procedure Act is
19 amended by adding Section 5-45.8 as follows:

20 (5 ILCS 100/5-45.8 new)
21 Sec. 5-45.8. Emergency rulemaking; Medicaid eligibility
22 expansion. To provide for the expeditious and timely
23 implementation of the changes made to paragraph 6 of Section

5-2 of the Illinois Public Aid Code by this amendatory Act of the 102nd General Assembly, emergency rules implementing the changes made to paragraph 6 of Section 5-2 of the Illinois Public Aid Code by this amendatory Act of the 102nd General Assembly may be adopted in accordance with Section 5-45 by the Department of Healthcare and Family Services. The adoption of emergency rules authorized by Section 5-45 and this Section is deemed to be necessary for the public interest, safety, and welfare.

This Section is repealed on January 1, 2027.

Section 25-5. The Children's Health Insurance Program Act is amended by adding Section 6 as follows:

(215 ILCS 106/6 new)

Sec. 6. Act inoperative. This Act is inoperative if (i) the Department of Healthcare and Family Services receives federal approval to make children younger than 19 who have countable income at or below 313% of the federal poverty level eligible for medical assistance under Article V of the Illinois Public Aid Code and (ii) the Department, upon federal approval, transitions children eligible for health care benefits under this Act into the medical assistance program established under Article V of the Illinois Public Aid Code.

Section 25-10. The Covering ALL KIDS Health Insurance Act

1 is amended by adding Section 6 as follows:

2 (215 ILCS 170/6 new)

3 Sec. 6. Act inoperative. This Act is inoperative if (i)
4 the Department of Healthcare and Family Services receives
5 federal approval to make children younger than 19 who have
6 countable income at or below 313% of the federal poverty level
7 eligible for medical assistance under Article V of the
8 Illinois Public Aid Code and (ii) the Department, upon federal
9 approval, transitions children eligible for health care
10 benefits under this Act into the medical assistance program
11 established under Article V of the Illinois Public Aid Code.

12 Section 25-15. The Illinois Public Aid Code is amended by
13 changing Sections 5-1.5, 5-2, and 12-4.35, and by adding
14 Sections 11-4.2, 11-22d, and 11-32 as follows:

15 (305 ILCS 5/5-1.5)
16 Sec. 5-1.5. COVID-19 public health emergency.
17 Notwithstanding any other provision of Articles V, XI, and XII
18 of this Code, the Department may take necessary actions to
19 address the COVID-19 public health emergency to the extent
20 such actions are required, approved, or authorized by the
21 United States Department of Health and Human Services, Centers
22 for Medicare and Medicaid Services. Such actions may continue
23 throughout the public health emergency and for up to 12 months

after the period ends, and may include, but are not limited to: accepting an applicant's or recipient's attestation of income, incurred medical expenses, residency, and insured status when electronic verification is not available; eliminating resource tests for some eligibility determinations; suspending redeterminations; suspending changes that would adversely affect an applicant's or recipient's eligibility; phone or verbal approval by an applicant to submit an application in lieu of applicant signature; allowing adult presumptive eligibility; allowing presumptive eligibility for children, pregnant women, and adults as often as twice per calendar year; paying for additional services delivered by telehealth; and suspending premium and co-payment requirements.

The Department's authority under this Section shall ~~only~~ extend to encompass, incorporate, or effectuate the terms, items, conditions, and other provisions approved, authorized, or required by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and shall not extend beyond the time of the COVID-19 public health emergency and up to 12 months after the period expires.

Any individual determined eligible for medical assistance under this Code as of or during the COVID-19 public health emergency may be treated as eligible for such medical assistance benefits during the COVID-19 public health emergency, and up to 12 months after the period expires, regardless of whether federally required or whether the

individual's eligibility may be State or federally funded, unless the individual requests a voluntary termination of eligibility or ceases to be a resident. This paragraph shall not restrict any determination of medical need or appropriateness for any particular service and shall not require continued coverage of any particular service that may be no longer necessary, appropriate, or otherwise authorized for an individual. Nothing shall prevent the Department from determining and properly establishing an individual's eligibility under a different category of eligibility.

(Source: P.A. 101-649, eff. 7-7-20.)

(305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

Sec. 5-2. Classes of persons eligible. Medical assistance under this Article shall be available to any of the following classes of persons in respect to whom a plan for coverage has been submitted to the Governor by the Illinois Department and approved by him. If changes made in this Section 5-2 require federal approval, they shall not take effect until such approval has been received:

1. Recipients of basic maintenance grants under Articles III and IV.

2. Beginning January 1, 2014, persons otherwise eligible for basic maintenance under Article III, excluding any eligibility requirements that are inconsistent with any federal law or federal regulation,

1 as interpreted by the U.S. Department of Health and Human
2 Services, but who fail to qualify thereunder on the basis
3 of need, and who have insufficient income and resources to
4 meet the costs of necessary medical care, including, but
5 not limited to, the following:
6 (a) All persons otherwise eligible for basic
7 maintenance under Article III but who fail to qualify
8 under that Article on the basis of need and who meet
9 either of the following requirements:
10 (i) their income, as determined by the
11 Illinois Department in accordance with any federal
12 requirements, is equal to or less than 100% of the
13 federal poverty level; or
14 (ii) their income, after the deduction of
15 costs incurred for medical care and for other
16 types of remedial care, is equal to or less than
17 100% of the federal poverty level.
18 (b) (Blank).
19 3. (Blank).
20 4. Persons not eligible under any of the preceding
21 paragraphs who fall sick, are injured, or die, not having
22 sufficient money, property or other resources to meet the
23 costs of necessary medical care or funeral and burial
24 expenses.
25 5.(a) Beginning January 1, 2020, women during
26 pregnancy and during the 12-month period beginning on the

1 last day of the pregnancy, together with their infants,
2 whose income is at or below 200% of the federal poverty
3 level. Until September 30, 2019, or sooner if the
4 maintenance of effort requirements under the Patient
5 Protection and Affordable Care Act are eliminated or may
6 be waived before then, women during pregnancy and during
7 the 12-month period beginning on the last day of the
8 pregnancy, whose countable monthly income, after the
9 deduction of costs incurred for medical care and for other
10 types of remedial care as specified in administrative
11 rule, is equal to or less than the Medical Assistance-No
12 Grant(C) (MANG(C)) Income Standard in effect on April 1,
13 2013 as set forth in administrative rule.
14 (b) The plan for coverage shall provide ambulatory
15 prenatal care to pregnant women during a presumptive
16 eligibility period and establish an income eligibility
17 standard that is equal to 200% of the federal poverty
18 level, provided that costs incurred for medical care are
19 not taken into account in determining such income
20 eligibility.
21 (c) The Illinois Department may conduct a
22 demonstration in at least one county that will provide
23 medical assistance to pregnant women, together with their
24 infants and children up to one year of age, where the
25 income eligibility standard is set up to 185% of the
26 nonfarm income official poverty line, as defined by the

federal Office of Management and Budget. The Illinois Department shall seek and obtain necessary authorization provided under federal law to implement such a demonstration. Such demonstration may establish resource standards that are not more restrictive than those established under Article IV of this Code.

6. (a) Subject to federal approval, children ~~Children~~ younger than age 19 when countable income is at or below 313% ~~133%~~ of the federal poverty level, as determined by the Department and in accordance with all applicable federal requirements. The Department is authorized to adopt emergency rules to implement the changes made to this paragraph by this amendatory Act of the 102nd General Assembly. Until September 30, 2019, or sooner if the maintenance of effort requirements under the Patient Protection and Affordable Care Act are eliminated or may be waived before then, children younger than age 19 whose countable monthly income, after the deduction of costs incurred for medical care and for other types of remedial care as specified in administrative rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1, 2013 as set forth in administrative rule.

(b) Children and youth who are under temporary custody or guardianship of the Department of Children and Family Services or who receive financial assistance in support of

an adoption or guardianship placement from the Department of Children and Family Services.

7. (Blank).

8. As required under federal law, persons who are eligible for Transitional Medical Assistance as a result of an increase in earnings or child or spousal support received. The plan for coverage for this class of persons shall:

(a) extend the medical assistance coverage to the extent required by federal law; and

(b) offer persons who have initially received 6 months of the coverage provided in paragraph (a) above, the option of receiving an additional 6 months of coverage, subject to the following:

(i) such coverage shall be pursuant to provisions of the federal Social Security Act;

(ii) such coverage shall include all services covered under Illinois' State Medicaid Plan;

(iii) no premium shall be charged for such coverage; and

(iv) such coverage shall be suspended in the event of a person's failure without good cause to file in a timely fashion reports required for this coverage under the Social Security Act and coverage shall be reinstated upon the filing of such reports if the person remains otherwise

eligible.

9. Persons with acquired immunodeficiency syndrome (AIDS) or with AIDS-related conditions with respect to whom there has been a determination that but for home or community-based services such individuals would require the level of care provided in an inpatient hospital, skilled nursing facility or intermediate care facility the cost of which is reimbursed under this Article. Assistance shall be provided to such persons to the maximum extent permitted under Title XIX of the Federal Social Security Act.

10. Participants in the long-term care insurance partnership program established under the Illinois Long-Term Care Partnership Program Act who meet the qualifications for protection of resources described in Section 15 of that Act.

11. Persons with disabilities who are employed and eligible for Medicaid, pursuant to Section 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and, subject to federal approval, persons with a medically improved disability who are employed and eligible for Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of the Social Security Act, as provided by the Illinois Department by rule. In establishing eligibility standards under this paragraph 11, the Department shall, subject to federal approval:

(a) set the income eligibility standard at not lower than 350% of the federal poverty level;

(b) exempt retirement accounts that the person cannot access without penalty before the age of 59 1/2, and medical savings accounts established pursuant to 26 U.S.C. 220;

(c) allow non-exempt assets up to $25,000 as to those assets accumulated during periods of eligibility under this paragraph 11; and

(d) continue to apply subparagraphs (b) and (c) in determining the eligibility of the person under this Article even if the person loses eligibility under this paragraph 11.

12. Subject to federal approval, persons who are eligible for medical assistance coverage under applicable provisions of the federal Social Security Act and the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000. Those eligible persons are defined to include, but not be limited to, the following persons:

(1) persons who have been screened for breast or cervical cancer under the U.S. Centers for Disease Control and Prevention Breast and Cervical Cancer Program established under Title XV of the federal Public Health Service ~~Services~~ Act in accordance with the requirements of Section 1504 of that Act as administered by the Illinois Department of Public

Health; and

(2) persons whose screenings under the above program were funded in whole or in part by funds appropriated to the Illinois Department of Public Health for breast or cervical cancer screening.

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the coverage under this paragraph 12 within 30 days after July 3, 2001 (the effective date of Public Act 92-47) ~~this amendatory Act of the 92nd General Assembly~~.

In addition to the persons who are eligible for medical assistance pursuant to subparagraphs (1) and (2) of this paragraph 12, and to be paid from funds appropriated to the Department for its medical programs, any uninsured person as defined by the Department in rules residing in Illinois who is younger than 65 years of age, who has been screened for breast and cervical cancer in accordance with standards and procedures adopted by the Department of Public Health for screening, and who is referred to the Department by the Department of Public Health as being in need of treatment for breast or cervical cancer is eligible for medical assistance benefits that are consistent with the benefits provided to those persons described in subparagraphs (1) and (2).

Medical assistance coverage for the persons who are eligible under the preceding sentence is not dependent on federal approval, but federal moneys may be used to pay for services provided under that coverage upon federal approval.

13. Subject to appropriation and to federal approval, persons living with HIV/AIDS who are not otherwise eligible under this Article and who qualify for services covered under Section 5-5.04 as provided by the Illinois Department by rule.

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet the income guidelines of paragraph 2(a) of this Section and (i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to

1 satisfy the criteria of this paragraph 14. If an
2 individual has an appeal pending regarding an application
3 for asylum before the Department of Homeland Security,
4 eligibility under this paragraph 14 may be extended until
5 a final decision is rendered on the appeal. The Department
6 may adopt rules governing the implementation of this
7 paragraph 14.

8 15. Family Care Eligibility.

9 (a) On and after July 1, 2012, a parent or other
10 caretaker relative who is 19 years of age or older when
11 countable income is at or below 133% of the federal
12 poverty level. A person may not spend down to become
13 eligible under this paragraph 15.

14 (b) Eligibility shall be reviewed annually.

15 (c) (Blank).

16 (d) (Blank).

17 (e) (Blank).

18 (f) (Blank).

19 (g) (Blank).

20 (h) (Blank).

21 (i) Following termination of an individual's
22 coverage under this paragraph 15, the individual must
23 be determined eligible before the person can be
24 re-enrolled.

25 16. Subject to appropriation, uninsured persons who
26 are not otherwise eligible under this Section who have

1 been certified and referred by the Department of Public
2 Health as having been screened and found to need
3 diagnostic evaluation or treatment, or both diagnostic
4 evaluation and treatment, for prostate or testicular
5 cancer. For the purposes of this paragraph 16, uninsured
6 persons are those who do not have creditable coverage, as
7 defined under the Health Insurance Portability and
8 Accountability Act, or have otherwise exhausted any
9 insurance benefits they may have had, for prostate or
10 testicular cancer diagnostic evaluation or treatment, or
11 both diagnostic evaluation and treatment. To be eligible,
12 a person must furnish a Social Security number. A person's
13 assets are exempt from consideration in determining
14 eligibility under this paragraph 16. Such persons shall be
15 eligible for medical assistance under this paragraph 16
16 for so long as they need treatment for the cancer. A person
17 shall be considered to need treatment if, in the opinion
18 of the person's treating physician, the person requires
19 therapy directed toward cure or palliation of prostate or
20 testicular cancer, including recurrent metastatic cancer
21 that is a known or presumed complication of prostate or
22 testicular cancer and complications resulting from the
23 treatment modalities themselves. Persons who require only
24 routine monitoring services are not considered to need
25 treatment. "Medical assistance" under this paragraph 16
26 shall be identical to the benefits provided under the

1 State's approved plan under Title XIX of the Social
2 Security Act. Notwithstanding any other provision of law,
3 the Department (i) does not have a claim against the
4 estate of a deceased recipient of services under this
5 paragraph 16 and (ii) does not have a lien against any
6 homestead property or other legal or equitable real
7 property interest owned by a recipient of services under
8 this paragraph 16.
9 17. Persons who, pursuant to a waiver approved by the
10 Secretary of the U.S. Department of Health and Human
11 Services, are eligible for medical assistance under Title
12 XIX or XXI of the federal Social Security Act.
13 Notwithstanding any other provision of this Code and
14 consistent with the terms of the approved waiver, the
15 Illinois Department, may by rule:
16 (a) Limit the geographic areas in which the waiver
17 program operates.
18 (b) Determine the scope, quantity, duration, and
19 quality, and the rate and method of reimbursement, of
20 the medical services to be provided, which may differ
21 from those for other classes of persons eligible for
22 assistance under this Article.
23 (c) Restrict the persons' freedom in choice of
24 providers.
25 18. Beginning January 1, 2014, persons aged 19 or
26 older, but younger than 65, who are not otherwise eligible

1 for medical assistance under this Section 5-2, who qualify
2 for medical assistance pursuant to 42 U.S.C.
3 1396a(a)(10)(A)(i)(VIII) and applicable federal
4 regulations, and who have income at or below 133% of the
5 federal poverty level plus 5% for the applicable family
6 size as determined pursuant to 42 U.S.C. 1396a(e)(14) and
7 applicable federal regulations. Persons eligible for
8 medical assistance under this paragraph 18 shall receive
9 coverage for the Health Benefits Service Package as that
10 term is defined in subsection (m) of Section 5-1.1 of this
11 Code. If Illinois' federal medical assistance percentage
12 (FMAP) is reduced below 90% for persons eligible for
13 medical assistance under this paragraph 18, eligibility
14 under this paragraph 18 shall cease no later than the end
15 of the third month following the month in which the
16 reduction in FMAP takes effect.
17 19. Beginning January 1, 2014, as required under 42
18 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18
19 and younger than age 26 who are not otherwise eligible for
20 medical assistance under paragraphs (1) through (17) of
21 this Section who (i) were in foster care under the
22 responsibility of the State on the date of attaining age
23 18 or on the date of attaining age 21 when a court has
24 continued wardship for good cause as provided in Section
25 2-31 of the Juvenile Court Act of 1987 and (ii) received
26 medical assistance under the Illinois Title XIX State Plan

1 or waiver of such plan while in foster care.
2 20. Beginning January 1, 2018, persons who are
3 foreign-born victims of human trafficking, torture, or
4 other serious crimes as defined in Section 2-19 of this
5 Code and their derivative family members if such persons:
6 (i) reside in Illinois; (ii) are not eligible under any of
7 the preceding paragraphs; (iii) meet the income guidelines
8 of subparagraph (a) of paragraph 2; and (iv) meet the
9 nonfinancial eligibility requirements of Sections 16-2,
10 16-3, and 16-5 of this Code. The Department may extend
11 medical assistance for persons who are foreign-born
12 victims of human trafficking, torture, or other serious
13 crimes whose medical assistance would be terminated
14 pursuant to subsection (b) of Section 16-5 if the
15 Department determines that the person, during the year of
16 initial eligibility (1) experienced a health crisis, (2)
17 has been unable, after reasonable attempts, to obtain
18 necessary information from a third party, or (3) has other
19 extenuating circumstances that prevented the person from
20 completing his or her application for status. The
21 Department may adopt any rules necessary to implement the
22 provisions of this paragraph.
23 21. Persons who are not otherwise eligible for medical
24 assistance under this Section who may qualify for medical
25 assistance pursuant to 42 U.S.C.
26 1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the

duration of any federal or State declared emergency due to COVID-19. Medical assistance to persons eligible for medical assistance solely pursuant to this paragraph 21 shall be limited to any in vitro diagnostic product (and the administration of such product) described in 42 U.S.C. 1396d(a)(3)(B) on or after March 18, 2020, any visit described in 42 U.S.C. 1396o(a)(2)(G), or any other medical assistance that may be federally authorized for this class of persons. The Department may also cover treatment of COVID-19 for this class of persons, or any similar category of uninsured individuals, to the extent authorized under a federally approved 1115 Waiver or other federal authority. Notwithstanding the provisions of Section 1-11 of this Code, due to the nature of the COVID-19 public health emergency, the Department may cover and provide the medical assistance described in this paragraph 21 to noncitizens who would otherwise meet the eligibility requirements for the class of persons described in this paragraph 21 for the duration of the State emergency period.

In implementing the provisions of Public Act 96-20, the Department is authorized to adopt only those rules necessary, including emergency rules. Nothing in Public Act 96-20 permits the Department to adopt rules or issue a decision that expands eligibility for the FamilyCare Program to a person whose income exceeds 185% of the Federal Poverty Level as determined

from time to time by the U.S. Department of Health and Human Services, unless the Department is provided with express statutory authority.

The eligibility of any such person for medical assistance under this Article is not affected by the payment of any grant under the Senior Citizens and Persons with Disabilities Property Tax Relief Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act.

The Department shall by rule establish the amounts of assets to be disregarded in determining eligibility for medical assistance, which shall at a minimum equal the amounts to be disregarded under the Federal Supplemental Security Income Program. The amount of assets of a single person to be disregarded shall not be less than $2,000, and the amount of assets of a married couple to be disregarded shall not be less than $3,000.

To the extent permitted under federal law, any person found guilty of a second violation of Article VIIIA shall be ineligible for medical assistance under this Article, as provided in Section 8A-8.

The eligibility of any person for medical assistance under this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person in cases of serious illness, as long as neither the person nor members of the person's family have actual control over the

donations or benefits or the disbursement of the donations or benefits.

Notwithstanding any other provision of this Code, if the United States Supreme Court holds Title II, Subtitle A, Section 2001(a) of Public Law 111-148 to be unconstitutional, or if a holding of Public Law 111-148 makes Medicaid eligibility allowed under Section 2001(a) inoperable, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal approval of a State Medicaid waiver on or after June 14, 2012 (the effective date of Public Act 97-687) ~~this amendatory Act of the 97th General Assembly~~, and any individuals enrolled in the Medical Assistance Program pursuant to eligibility permitted as a result of such a State Medicaid waiver shall become immediately ineligible.

Notwithstanding any other provision of this Code, if an Act of Congress that becomes a Public Law eliminates Section 2001(a) of Public Law 111-148, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal approval of a State Medicaid waiver on or after June 14, 2012 (the effective date of Public Act 97-687) ~~this amendatory Act of the 97th General Assembly~~, and any individuals enrolled in the Medical Assistance Program pursuant to eligibility permitted as a result of such a State Medicaid waiver shall become immediately ineligible.

Effective October 1, 2013, the determination of eligibility of persons who qualify under paragraphs 5, 6, 8, 15, 17, and 18 of this Section shall comply with the requirements of 42 U.S.C. 1396a(e)(14) and applicable federal regulations.

The Department of Healthcare and Family Services, the Department of Human Services, and the Illinois health insurance marketplace shall work cooperatively to assist persons who would otherwise lose health benefits as a result of changes made under Public Act 98-104 ~~this amendatory Act of the 98th General Assembly~~ to transition to other health insurance coverage.

(Source: P.A. 101-10, eff. 6-5-19; 101-649, eff. 7-7-20; revised 8-24-20.)

(305 ILCS 5/11-4.2 new)

Sec. 11-4.2. Application assistance for enrolling individuals in the medical assistance program.

(a) The Department shall have procedures to allow application agents to assist in enrolling individuals in the medical assistance program. As used in this Section, "application agent" means an organization or individual, such as a licensed health care provider, school, youth service agency, employer, labor union, local chamber of commerce, community-based organization, or other organization, approved by the Department to assist in enrolling individuals in the

1 medical assistance program.
2 (b) At the Department's discretion, technical assistance
3 payments may be made available for approved applications
4 facilitated by an application agent. The Department shall
5 permit day and temporary labor service agencies, as defined in
6 the Day and Temporary Labor Services Act, doing business in
7 Illinois to enroll as unpaid application agents. As
8 established in the Free Healthcare Benefits Application
9 Assistance Act, it shall be unlawful for any person to charge
10 another person or family for assisting in completing and
11 submitting an application for enrollment in the medical
12 assistance program.
13 (c) Existing enrollment agreements or contracts for all
14 application agents, technical assistance payments, and
15 outreach grants that were authorized under Section 22 of the
16 Children's Health Insurance Program Act and Sections 25 and 30
17 of the Covering ALL KIDS Health Insurance Act prior to those
18 Acts becoming inoperative shall continue to be authorized
19 under this Section per the terms of the agreement or contract
20 until modified, amended, or terminated.

21 (305 ILCS 5/11-22d new)
22 Sec. 11-22d. Savings provisions.
23 (a) Notwithstanding any amendments or provisions in this
24 amendatory Act of the 102nd General Assembly which would make
25 the Children's Health Insurance Program Act or the Covering

ALL KIDS Health Insurance Act inoperative, Sections 11-22a, 11-22b, and 11-22c of this Code shall remain in force for the commencement or continuation of any cause of action that (i) accrued prior to the effective date of this amendatory Act of the 102nd General Assembly or the date upon which the Department receives federal approval of the changes made to paragraph (6) of Section 5-2 by this amendatory Act of the 102nd General Assembly, whichever is later, and (ii) concerns the recovery of any amount expended by the State for health care benefits provided under the Children's Health Insurance Program Act or the Covering ALL KIDS Health Insurance Act prior to those Acts becoming inoperative. Any timely action brought under Sections 11-22a, 11-22b, and 11-22c shall be decided in accordance with those Sections as they existed when the cause of action accrued.

(b) Notwithstanding any amendments or provisions in this amendatory Act of the 102nd General Assembly which would make the Children's Health Insurance Program Act or the Covering ALL KIDS Health Insurance Act inoperative, paragraph (2) of Section 12-9 of this Code shall remain in force as to recoveries made by the Department of Healthcare and Family Services from any cause of action commenced or continued in accordance with subsection (a).

(305 ILCS 5/11-32 new)

Sec. 11-32. Premium debts; forgiveness, compromise,

1 reduction. The Department may forgive, compromise, or reduce
2 any debt owed by a former or current recipient of medical
3 assistance under this Code or health care benefits under the
4 Children's Health Insurance Program or the Covering ALL KIDS
5 Health Insurance Program that is related to any premium that
6 was determined or imposed in accordance with (i) the
7 Children's Health Insurance Program Act or the Covering ALL
8 KIDS Health Insurance Act prior to those Acts becoming
9 inoperative or (ii) any corresponding administrative rule.

10 (305 ILCS 5/12-4.35)
11 Sec. 12-4.35. Medical services for certain noncitizens.
12 (a) Notwithstanding Section 1-11 of this Code or Section
13 20(a) of the Children's Health Insurance Program Act, the
14 Department of Healthcare and Family Services may provide
15 medical services to noncitizens who have not yet attained 19
16 years of age and who are not eligible for medical assistance
17 under Article V of this Code or under the Children's Health
18 Insurance Program created by the Children's Health Insurance
19 Program Act due to their not meeting the otherwise applicable
20 provisions of Section 1-11 of this Code or Section 20(a) of the
21 Children's Health Insurance Program Act. The medical services
22 available, standards for eligibility, and other conditions of
23 participation under this Section shall be established by rule
24 by the Department; however, any such rule shall be at least as
25 restrictive as the rules for medical assistance under Article

V of this Code or the Children's Health Insurance Program created by the Children's Health Insurance Program Act.

(a-5) Notwithstanding Section 1-11 of this Code, the Department of Healthcare and Family Services may provide medical assistance in accordance with Article V of this Code to noncitizens over the age of 65 years of age who are not eligible for medical assistance under Article V of this Code due to their not meeting the otherwise applicable provisions of Section 1-11 of this Code, whose income is at or below 100% of the federal poverty level after deducting the costs of medical or other remedial care, and who would otherwise meet the eligibility requirements in Section 5-2 of this Code. The medical services available, standards for eligibility, and other conditions of participation under this Section shall be established by rule by the Department; however, any such rule shall be at least as restrictive as the rules for medical assistance under Article V of this Code.

(b) The Department is authorized to take any action that would not otherwise be prohibited by applicable law, including without limitation cessation or limitation of enrollment, reduction of available medical services, and changing standards for eligibility, that is deemed necessary by the Department during a State fiscal year to assure that payments under this Section do not exceed available funds.

(c) (Blank). ~~Continued enrollment of individuals into the program created under subsection (a) of this Section in any~~

~~fiscal year is contingent upon continued enrollment of individuals into the Children's Health Insurance Program during that fiscal year.~~

(d) (Blank).

(Source: P.A. 101-636, eff. 6-10-20.)

Article 30.

Section 30-5. The Illinois Public Aid Code is amended by changing Sections 5-5 and 5-5f 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

1 for pregnant women, provided by an individual licensed to
2 practice dentistry or dental surgery; for purposes of this
3 item (10), "dental services" means diagnostic, preventive, or
4 corrective procedures provided by or under the supervision of
5 a dentist in the practice of his or her profession; (11)
6 physical therapy and related services; (12) prescribed drugs,
7 dentures, and prosthetic devices; and eyeglasses prescribed by
8 a physician skilled in the diseases of the eye, or by an
9 optometrist, whichever the person may select; (13) other
10 diagnostic, screening, preventive, and rehabilitative
11 services, including to ensure that the individual's need for
12 intervention or treatment of mental disorders or substance use
13 disorders or co-occurring mental health and substance use
14 disorders is determined using a uniform screening, assessment,
15 and evaluation process inclusive of criteria, for children and
16 adults; for purposes of this item (13), a uniform screening,
17 assessment, and evaluation process refers to a process that
18 includes an appropriate evaluation and, as warranted, a
19 referral; "uniform" does not mean the use of a singular
20 instrument, tool, or process that all must utilize; (14)
21 transportation and such other expenses as may be necessary;
22 (15) medical treatment of sexual assault survivors, as defined
23 in Section 1a of the Sexual Assault Survivors Emergency
24 Treatment Act, for injuries sustained as a result of the
25 sexual assault, including examinations and laboratory tests to
26 discover evidence which may be used in criminal proceedings

1 arising from the sexual assault; (16) the diagnosis and
2 treatment of sickle cell anemia; (16.5) services performed by
3 a chiropractic physician licensed under the Medical Practice
4 Act of 1987 and acting within the scope of his or her license,
5 including, but not limited to, chiropractic manipulative
6 treatment; and (17) any other medical care, and any other type
7 of remedial care recognized under the laws of this State. The
8 term "any other type of remedial care" shall include nursing
9 care and nursing home service for persons who rely on
10 treatment by spiritual means alone through prayer for healing.

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

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

23 Notwithstanding any other provision of this Code, the
24 Illinois Department may not require, as a condition of payment
25 for any laboratory test authorized under this Article, that a
26 physician's handwritten signature appear on the laboratory

test order form. The Illinois Department may, however, impose other appropriate requirements regarding laboratory test order documentation.

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department 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

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

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

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

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

12 For purposes of this Section:

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

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

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

1 "Breast tomosynthesis" means a radiologic procedure that
2 involves the acquisition of projection images over the
3 stationary breast to produce cross-sectional digital
4 three-dimensional images of the breast.

5 If, at any time, the Secretary of the United States
6 Department of Health and Human Services, or its successor
7 agency, promulgates rules or regulations to be published in
8 the Federal Register or publishes a comment in the Federal
9 Register or issues an opinion, guidance, or other action that
10 would require the State, pursuant to any provision of the
11 Patient Protection and Affordable Care Act (Public Law
12 111-148), including, but not limited to, 42 U.S.C.
13 18031(d)(3)(B) or any successor provision, to defray the cost
14 of any coverage for breast tomosynthesis outlined in this
15 paragraph, then the requirement that an insurer cover breast
16 tomosynthesis is inoperative other than any such coverage
17 authorized under Section 1902 of the Social Security Act, 42
18 U.S.C. 1396a, and the State shall not assume any obligation
19 for the cost of coverage for breast tomosynthesis set forth in
20 this paragraph.

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

26 On and after January 1, 2012, providers participating in a

1 quality improvement program approved by the Department shall
2 be reimbursed for screening and diagnostic mammography at the
3 same rate as the Medicare program's rates, including the
4 increased reimbursement for digital mammography.

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

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

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

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

of the provision set forth in this paragraph.

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

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

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. On or after July 1, 2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within

1 metropolitan Chicago. An evaluation of the pilot program shall
2 be carried out measuring health outcomes and cost of care for
3 those served by the pilot program compared to similarly
4 situated patients who are not served by the pilot program.
5 The Department shall require all networks of care to
6 develop a means either internally or by contract with experts
7 in navigation and community outreach to navigate cancer
8 patients to comprehensive care in a timely fashion. The
9 Department shall require all networks of care to include
10 access for patients diagnosed with cancer to at least one
11 academic commission on cancer-accredited cancer program as an
12 in-network covered benefit.
13 Any medical or health care provider shall immediately
14 recommend, to any pregnant woman who is being provided
15 prenatal services and is suspected of having a substance use
16 disorder as defined in the Substance Use Disorder Act,
17 referral to a local substance use disorder treatment program
18 licensed by the Department of Human Services or to a licensed
19 hospital which provides substance abuse treatment services.
20 The Department of Healthcare and Family Services shall assure
21 coverage for the cost of treatment of the drug abuse or
22 addiction for pregnant recipients in accordance with the
23 Illinois Medicaid Program in conjunction with the Department
24 of Human Services.
25 All medical providers providing medical assistance to
26 pregnant women under this Code shall receive information from

1 the Department on the availability of services under any
2 program providing case management services for addicted women,
3 including information on appropriate referrals for other
4 social services that may be needed by addicted women in
5 addition to treatment for addiction.

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

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

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

26 The Illinois Department may develop and contract with

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

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

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

(2) The Department may elect to consider and negotiate financial incentives to encourage the development of

1 Partnerships and the efficient delivery of medical care.
2 (3) Persons receiving medical services through
3 Partnerships may receive medical and case management
4 services above the level usually offered through the
5 medical assistance program.
6 Medical providers shall be required to meet certain
7 qualifications to participate in Partnerships to ensure the
8 delivery of high quality medical services. These
9 qualifications shall be determined by rule of the Illinois
10 Department and may be higher than qualifications for
11 participation in the medical assistance program. Partnership
12 sponsors may prescribe reasonable additional qualifications
13 for participation by medical providers, only with the prior
14 written approval of the Illinois Department.
15 Nothing in this Section shall limit the free choice of
16 practitioners, hospitals, and other providers of medical
17 services by clients. In order to ensure patient freedom of
18 choice, the Illinois Department shall immediately promulgate
19 all rules and take all other necessary actions so that
20 provided services may be accessed from therapeutically
21 certified optometrists to the full extent of the Illinois
22 Optometric Practice Act of 1987 without discriminating between
23 service providers.
24 The Department shall apply for a waiver from the United
25 States Health Care Financing Administration to allow for the
26 implementation of Partnerships under this Section.

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

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

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

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

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

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

1 inquiries could indicate potential existence of claims or
2 liens for the Illinois Department.
3 Enrollment of a vendor shall be subject to a provisional
4 period and shall be conditional for one year. During the
5 period of conditional enrollment, the Department may terminate
6 the vendor's eligibility to participate in, or may disenroll
7 the vendor from, the medical assistance program without cause.
8 Unless otherwise specified, such termination of eligibility or
9 disenrollment is not subject to the Department's hearing
10 process. However, a disenrolled vendor may reapply without
11 penalty.
12 The Department has the discretion to limit the conditional
13 enrollment period for vendors based upon category of risk of
14 the vendor.
15 Prior to enrollment and during the conditional enrollment
16 period in the medical assistance program, all vendors shall be
17 subject to enhanced oversight, screening, and review based on
18 the risk of fraud, waste, and abuse that is posed by the
19 category of risk of the vendor. The Illinois Department shall
20 establish the procedures for oversight, screening, and review,
21 which may include, but need not be limited to: criminal and
22 financial background checks; fingerprinting; license,
23 certification, and authorization verifications; unscheduled or
24 unannounced site visits; database checks; prepayment audit
25 reviews; audits; payment caps; payment suspensions; and other
26 screening as required by federal or State law.

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

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

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

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

1 until the provider has been notified of the error.
2 (3) In the case of a provider for whom the Illinois
3 Department initiates the monthly billing process.
4 (4) In the case of a provider operated by a unit of
5 local government with a population exceeding 3,000,000
6 when local government funds finance federal participation
7 for claims payments.
8 For claims for services rendered during a period for which
9 a recipient received retroactive eligibility, claims must be
10 filed within 180 days after the Department determines the
11 applicant is eligible. For claims for which the Illinois
12 Department is not the primary payer, claims must be submitted
13 to the Illinois Department within 180 days after the final
14 adjudication by the primary payer.
15 In the case of long term care facilities, within 45
16 calendar days of receipt by the facility of required
17 prescreening information, new admissions with associated
18 admission documents shall be submitted through the Medical
19 Electronic Data Interchange (MEDI) or the Recipient
20 Eligibility Verification (REV) System or shall be submitted
21 directly to the Department of Human Services using required
22 admission forms. Effective September 1, 2014, admission
23 documents, including all prescreening information, must be
24 submitted through MEDI or REV. Confirmation numbers assigned
25 to an accepted transaction shall be retained by a facility to
26 verify timely submittal. Once an admission transaction has

1 been completed, all resubmitted claims following prior
2 rejection are subject to receipt no later than 180 days after
3 the admission transaction has been completed.

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

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

22 The Illinois Department shall enter into agreements with
23 State agencies and departments, and is authorized to enter
24 into agreements with federal agencies and departments, under
25 which such agencies and departments shall share data necessary
26 for medical assistance program integrity functions and

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

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

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of 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 orthotic devices as defined in the Orthotics, Prosthetics, and Pedorthics Practice Act and complex rehabilitation technology products and associated services) through the State's assistive technology program's reutilization program, using staff with the Assistive Technology Professional (ATP) Certification if the refurbished durable medical equipment: (i) is available; (ii) is less expensive, including shipping costs, than new durable medical equipment of the same type; (iii) is able to withstand at least 3 years of use; (iv) is cleaned, disinfected, sterilized, and safe in accordance with federal Food and Drug Administration regulations and guidance governing the reprocessing of medical devices in health care settings; and (v) equally meets the needs of the recipient or enrollee. The reutilization program shall confirm that the recipient or enrollee is not already in receipt of same or similar equipment from another service provider, and that the

1 refurbished durable medical equipment equally meets the needs
2 of the recipient or enrollee. Nothing in this paragraph shall
3 be construed to limit recipient or enrollee choice to obtain
4 new durable medical equipment or place any additional prior
5 authorization conditions on enrollees of managed care
6 organizations.

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

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

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

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

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

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

26 (c) current rate structures and proposed changes in

1 those rate structures for the various medical vendors; and
2 (d) efforts at utilization review and control by the
3 Illinois Department.
4 The period covered by each report shall be the 3 years
5 ending on the June 30 prior to the report. The report shall
6 include suggested legislation for consideration by the General
7 Assembly. The requirement for reporting to the General
8 Assembly shall be satisfied by filing copies of the report as
9 required by Section 3.1 of the General Assembly Organization
10 Act, and filing such additional copies with the State
11 Government Report Distribution Center for the General Assembly
12 as is required under paragraph (t) of Section 7 of the State
13 Library Act.
14 Rulemaking authority to implement Public Act 95-1045, if
15 any, is conditioned on the rules being adopted in accordance
16 with all provisions of the Illinois Administrative Procedure
17 Act and all rules and procedures of the Joint Committee on
18 Administrative Rules; any purported rule not so adopted, for
19 whatever reason, is unauthorized.
20 On and after July 1, 2012, the Department shall reduce any
21 rate of reimbursement for services or other payments or alter
22 any methodologies authorized by this Code to reduce any rate
23 of reimbursement for services or other payments in accordance
24 with Section 5-5e.
25 Because kidney transplantation can be an appropriate,
26 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. Providers under this Section shall be prior approved and certified by the Department to perform kidney transplantation and the services under this Section shall be limited to services associated with kidney transplantation.

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

On or after July 1, 2015, opioid antagonists prescribed

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

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

24 A federally qualified health center, as defined in Section
25 1905(l)(2)(B) of the federal Social Security Act, shall be
26 reimbursed by the Department in accordance with the federally

qualified health center's encounter rate for services provided to medical assistance recipients that are performed by a dental hygienist, as defined under the Illinois Dental Practice Act, working under the general supervision of a dentist and employed by a federally qualified health center.
(Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; revised 9-18-19.)

(305 ILCS 5/5-5f)

Sec. 5-5f. Elimination and limitations of medical assistance services. Notwithstanding any other provision of this Code to the contrary, on and after July 1, 2012:

(a) The following service ~~services~~ shall no longer be a covered service available under this Code: group psychotherapy for residents of any facility licensed under the Nursing Home Care Act or the Specialized Mental Health Rehabilitation Act of 2013~~; and adult chiropractic services~~.

(b) The Department shall place the following limitations on services: (i) the Department shall limit adult eyeglasses to one pair every 2 years; however, the limitation does not apply to an individual who needs

1 different eyeglasses following a surgical procedure such
2 as cataract surgery; (ii) the Department shall set an
3 annual limit of a maximum of 20 visits for each of the
4 following services: adult speech, hearing, and language
5 therapy services, adult occupational therapy services, and
6 physical therapy services; on or after October 1, 2014,
7 the annual maximum limit of 20 visits shall expire but the
8 Department may require prior approval for all individuals
9 for speech, hearing, and language therapy services,
10 occupational therapy services, and physical therapy
11 services; (iii) the Department shall limit adult podiatry
12 services to individuals with diabetes; on or after October
13 1, 2014, podiatry services shall not be limited to
14 individuals with diabetes; (iv) the Department shall pay
15 for caesarean sections at the normal vaginal delivery rate
16 unless a caesarean section was medically necessary; (v)
17 the Department shall limit adult dental services to
18 emergencies; beginning July 1, 2013, the Department shall
19 ensure that the following conditions are recognized as
20 emergencies: (A) dental services necessary for an
21 individual in order for the individual to be cleared for a
22 medical procedure, such as a transplant; (B) extractions
23 and dentures necessary for a diabetic to receive proper
24 nutrition; (C) extractions and dentures necessary as a
25 result of cancer treatment; and (D) dental services
26 necessary for the health of a pregnant woman prior to

1 delivery of her baby; on or after July 1, 2014, adult
2 dental services shall no longer be limited to emergencies,
3 and dental services necessary for the health of a pregnant
4 woman prior to delivery of her baby shall continue to be
5 covered; and (vi) effective July 1, 2012, the Department
6 shall place limitations and require concurrent review on
7 every inpatient detoxification stay to prevent repeat
8 admissions to any hospital for detoxification within 60
9 days of a previous inpatient detoxification stay. The
10 Department shall convene a workgroup of hospitals,
11 substance abuse providers, care coordination entities,
12 managed care plans, and other stakeholders to develop
13 recommendations for quality standards, diversion to other
14 settings, and admission criteria for patients who need
15 inpatient detoxification, which shall be published on the
16 Department's website no later than September 1, 2013.
17 (c) The Department shall require prior approval of the
18 following services: wheelchair repairs costing more than
19 $400, coronary artery bypass graft, and bariatric surgery
20 consistent with Medicare standards concerning patient
21 responsibility. Wheelchair repair prior approval requests
22 shall be adjudicated within one business day of receipt of
23 complete supporting documentation. Providers may not break
24 wheelchair repairs into separate claims for purposes of
25 staying under the $400 threshold for requiring prior
26 approval. The wholesale price of manual and power

wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

(d) The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a minimum, $40,000,000.

(e) The Department shall establish utilization controls for the hospice program such that it shall not pay for other care services when an individual is in hospice.

(f) For home health services, the Department shall require Medicare certification of providers participating in the program and implement the Medicare face-to-face

1 encounter rule. The Department shall require providers to
2 implement auditable electronic service verification based
3 on global positioning systems or other cost-effective
4 technology.
5 (g) For the Home Services Program operated by the
6 Department of Human Services and the Community Care
7 Program operated by the Department on Aging, the
8 Department of Human Services, in cooperation with the
9 Department on Aging, shall implement an electronic service
10 verification based on global positioning systems or other
11 cost-effective technology.
12 (h) Effective with inpatient hospital admissions on or
13 after July 1, 2012, the Department shall reduce the
14 payment for a claim that indicates the occurrence of a
15 provider-preventable condition during the admission as
16 specified by the Department in rules. The Department shall
17 not pay for services related to an other
18 provider-preventable condition.
19 As used in this subsection (h):
20 "Provider-preventable condition" means a health care
21 acquired condition as defined under the federal Medicaid
22 regulation found at 42 CFR 447.26 or an other
23 provider-preventable condition.
24 "Other provider-preventable condition" means a wrong
25 surgical or other invasive procedure performed on a
26 patient, a surgical or other invasive procedure performed

on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

(i) The Department shall implement cost savings initiatives for advanced imaging services, cardiac imaging services, pain management services, and back surgery. Such initiatives shall be designed to achieve annual costs savings.

(j) The Department shall ensure that beneficiaries with a diagnosis of epilepsy or seizure disorder in Department records will not require prior approval for anticonvulsants.

(Source: P.A. 100-135, eff. 8-18-17; 101-209, eff. 8-5-19.)

Article 35.

Section 35-5. The Illinois Public Aid Code is amended by changing Section 5-5 and by adding Section 5-42 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

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

instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

Notwithstanding any other provision of this Section, all tobacco cessation medications approved by the United States Food and Drug Administration and all individual and group tobacco cessation counseling services and telephone-based counseling services and tobacco cessation medications provided

1 through the Illinois Tobacco Quitline shall be covered under
2 the medical assistance program for persons who are otherwise
3 eligible for assistance under this Article. The Department
4 shall comply with all federal requirements necessary to obtain
5 federal financial participation, as specified in 42 CFR
6 433.15(b)(7), for telephone-based counseling services provided
7 through the Illinois Tobacco Quitline, including, but not
8 limited to: (i) entering into a memorandum of understanding or
9 interagency agreement with the Department of Public Health, as
10 administrator of the Illinois Tobacco Quitline; and (ii)
11 developing a cost allocation plan for Medicaid-allowable
12 Illinois Tobacco Quitline services in accordance with 45 CFR
13 95.507. The Department shall submit the memorandum of
14 understanding or interagency agreement, the cost allocation
15 plan, and all other necessary documentation to the Centers for
16 Medicare and Medicaid Services for review and approval.
17 Coverage under this paragraph shall be contingent upon federal
18 approval.

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

24 Notwithstanding any other provision of this Code, the
25 Illinois Department may not require, as a condition of payment
26 for any laboratory test authorized under this Article, that a

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

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

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

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

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

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

1 The Department shall not impose a deductible, coinsurance,
2 copayment, or any other cost-sharing requirement on the
3 coverage provided under this paragraph; except that this
4 sentence does not apply to coverage of diagnostic mammograms
5 to the extent such coverage would disqualify a high-deductible
6 health plan from eligibility for a health savings account
7 pursuant to Section 223 of the Internal Revenue Code (26
8 U.S.C. 223).
9 All screenings shall include a physical breast exam,
10 instruction on self-examination and information regarding the
11 frequency of self-examination and its value as a preventative
12 tool.
13 For purposes of this Section:
14 "Diagnostic mammogram" means a mammogram obtained using
15 diagnostic mammography.
16 "Diagnostic mammography" means a method of screening that
17 is designed to evaluate an abnormality in a breast, including
18 an abnormality seen or suspected on a screening mammogram or a
19 subjective or objective abnormality otherwise detected in the
20 breast.
21 "Low-dose mammography" means the x-ray examination of the
22 breast using equipment dedicated specifically for mammography,
23 including the x-ray tube, filter, compression device, and
24 image receptor, with an average radiation exposure delivery of
25 less than one rad per breast for 2 views of an average size
26 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 Patient Protection and Affordable Care Act (Public Law 111-148), including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any successor provision, to defray the cost of any coverage for breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover breast tomosynthesis is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this paragraph.

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

1 On and after January 1, 2012, providers participating in a
2 quality improvement program approved by the Department shall
3 be reimbursed for screening and diagnostic mammography at the
4 same rate as the Medicare program's rates, including the
5 increased reimbursement for digital mammography.
6 The Department shall convene an expert panel including
7 representatives of hospitals, free-standing mammography
8 facilities, and doctors, including radiologists, to establish
9 quality standards for mammography.
10 On and after January 1, 2017, providers participating in a
11 breast cancer treatment quality improvement program approved
12 by the Department shall be reimbursed for breast cancer
13 treatment at a rate that is no lower than 95% of the Medicare
14 program's rates for the data elements included in the breast
15 cancer treatment quality program.
16 The Department shall convene an expert panel, including
17 representatives of hospitals, free-standing breast cancer
18 treatment centers, breast cancer quality organizations, and
19 doctors, including breast surgeons, reconstructive breast
20 surgeons, oncologists, and primary care providers to establish
21 quality standards for breast cancer treatment.
22 Subject to federal approval, the Department shall
23 establish a rate methodology for mammography at federally
24 qualified health centers and other encounter-rate clinics.
25 These clinics or centers may also collaborate with other
26 hospital-based mammography facilities. By January 1, 2016, the

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

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

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

18 The Department shall devise a means of case-managing or
19 patient navigation for beneficiaries diagnosed with breast
20 cancer. This program shall initially operate as a pilot
21 program in areas of the State with the highest incidence of
22 mortality related to breast cancer. At least one pilot program
23 site shall be in the metropolitan Chicago area and at least one
24 site shall be outside the metropolitan Chicago area. On or
25 after July 1, 2016, the pilot program shall be expanded to
26 include one site in western Illinois, one site in southern

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

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

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

26 All medical providers providing medical assistance to

pregnant women under this Code shall receive information from the Department on the availability of services under any program providing case management services for addicted women, including information on appropriate referrals for other social services that may be needed by addicted women in addition to treatment for addiction.

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

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

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

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

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

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

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

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

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

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the delivery of high quality medical services. These qualifications shall be determined by rule of the Illinois 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

1 implementation of Partnerships under this Section.
2 The Illinois Department shall require health care
3 providers to maintain records that document the medical care
4 and services provided to recipients of Medical Assistance
5 under this Article. Such records must be retained for a period
6 of not less than 6 years from the date of service or as
7 provided by applicable State law, whichever period is longer,
8 except that if an audit is initiated within the required
9 retention period then the records must be retained until the
10 audit is completed and every exception is resolved. The
11 Illinois Department shall require health care providers to
12 make available, when authorized by the patient, in writing,
13 the medical records in a timely fashion to other health care
14 providers who are treating or serving persons eligible for
15 Medical Assistance under this Article. All dispensers of
16 medical services shall be required to maintain and retain
17 business and professional records sufficient to fully and
18 accurately document the nature, scope, details and receipt of
19 the health care provided to persons eligible for medical
20 assistance under this Code, in accordance with regulations
21 promulgated by the Illinois Department. The rules and
22 regulations shall require that proof of the receipt of
23 prescription drugs, dentures, prosthetic devices and
24 eyeglasses by eligible persons under this Section accompany
25 each claim for reimbursement submitted by the dispenser of
26 such medical services. No such claims for reimbursement shall

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

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

1 acceptance and payment of nursing home claims.
2 Notwithstanding any other law to the contrary, the
3 Illinois Department shall, within 365 days after August 15,
4 2014 (the effective date of Public Act 98-963), establish
5 procedures to permit ID/DD facilities licensed under the ID/DD
6 Community Care Act and MC/DD facilities licensed under the
7 MC/DD Act to submit monthly billing claims for reimbursement
8 purposes. Following development of these procedures, the
9 Department shall have an additional 365 days to test the
10 viability of the new system and to ensure that any necessary
11 operational or structural changes to its information
12 technology platforms are implemented.
13 The Illinois Department shall require all dispensers of
14 medical services, other than an individual practitioner or
15 group of practitioners, desiring to participate in the Medical
16 Assistance program established under this Article to disclose
17 all financial, beneficial, ownership, equity, surety or other
18 interests in any and all firms, corporations, partnerships,
19 associations, business enterprises, joint ventures, agencies,
20 institutions or other legal entities providing any form of
21 health care services in this State under this Article.
22 The Illinois Department may require that all dispensers of
23 medical services desiring to participate in the medical
24 assistance program established under this Article disclose,
25 under such terms and conditions as the Illinois Department may
26 by rule establish, all inquiries from clients and attorneys

regarding medical bills paid by the Illinois Department, which inquiries could indicate potential existence of claims or liens for the Illinois Department.

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

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

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

screening as required by federal or State law.

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

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

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

(2) In the case of errors attributable to the Illinois Department or any of its claims processing intermediaries which result in an inability to receive, process, or

adjudicate a claim, the 180-day period shall not begin until the provider has been notified of the error.

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

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

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

In the case of long term care facilities, within 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 access to confidential and other information and data necessary to perform eligibility and payment verifications and other Illinois Department functions. This includes, but is not limited to: information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary

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

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

take any action or acquire any products or services.

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1) immediate repair or replacement of such devices by recipients; and (2) rental, lease, purchase or lease-purchase of durable medical equipment in a cost-effective manner, taking into consideration the recipient's medical prognosis, the extent of 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 orthotic devices as defined in the Orthotics, Prosthetics, and Pedorthics Practice Act and complex rehabilitation technology products and associated services) through the State's assistive technology program's reutilization program, using staff with the Assistive Technology Professional (ATP) Certification if the refurbished durable medical equipment: (i) is available; (ii) is less expensive, including shipping costs, than new durable medical equipment of the same type; (iii) is able to withstand at least 3 years of use; (iv) is cleaned, disinfected, sterilized, and safe in accordance with federal Food and Drug Administration regulations and guidance governing the reprocessing of medical devices in health care settings; and (v) equally meets the needs of the recipient or enrollee. The reutilization program shall confirm that the recipient or enrollee is not already in receipt of same or

similar equipment from another service provider, and that the refurbished durable medical equipment equally meets the needs of the recipient or enrollee. Nothing in this paragraph shall be construed to limit recipient or enrollee choice to obtain new durable medical equipment or place any additional prior authorization conditions on enrollees of managed care organizations.

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

1 (v) no later than October 1, 2013, establish procedures to
2 permit long term care providers access to eligibility scores
3 for individuals with an admission date who are seeking or
4 receiving services from the long term care provider. In order
5 to select the minimum level of care eligibility criteria, the
6 Governor shall establish a workgroup that includes affected
7 agency representatives and stakeholders representing the
8 institutional and home and community-based long term care
9 interests. This Section shall not restrict the Department from
10 implementing lower level of care eligibility criteria for
11 community-based services in circumstances where federal
12 approval has been granted.
13 The Illinois Department shall develop and operate, in
14 cooperation with other State Departments and agencies and in
15 compliance with applicable federal laws and regulations,
16 appropriate and effective systems of health care evaluation
17 and programs for monitoring of utilization of health care
18 services and facilities, as it affects persons eligible for
19 medical assistance under this Code.
20 The Illinois Department shall report annually to the
21 General Assembly, no later than the second Friday in April of
22 1979 and each year thereafter, in regard to:
23 (a) actual statistics and trends in utilization of
24 medical services by public aid recipients;
25 (b) actual statistics and trends in the provision of
26 the various medical services by medical vendors;

1 (c) current rate structures and proposed changes in
2 those rate structures for the various medical vendors; and
3 (d) efforts at utilization review and control by the
4 Illinois Department.
5 The period covered by each report shall be the 3 years
6 ending on the June 30 prior to the report. The report shall
7 include suggested legislation for consideration by the General
8 Assembly. The requirement for reporting to the General
9 Assembly shall be satisfied by filing copies of the report as
10 required by Section 3.1 of the General Assembly Organization
11 Act, and filing such additional copies with the State
12 Government Report Distribution Center for the General Assembly
13 as is required under paragraph (t) of Section 7 of the State
14 Library Act.
15 Rulemaking authority to implement Public Act 95-1045, if
16 any, is conditioned on the rules being adopted in accordance
17 with all provisions of the Illinois Administrative Procedure
18 Act and all rules and procedures of the Joint Committee on
19 Administrative Rules; any purported rule not so adopted, for
20 whatever reason, is unauthorized.
21 On and after July 1, 2012, the Department shall reduce any
22 rate of reimbursement for services or other payments or alter
23 any methodologies authorized by this Code to reduce any rate
24 of reimbursement for services or other payments in accordance
25 with Section 5-5e.
26 Because kidney transplantation can be an appropriate,

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

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

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

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

25 A federally qualified health center, as defined in Section
26 1905(l)(2)(B) of the federal Social Security Act, shall be

1 reimbursed by the Department in accordance with the federally
2 qualified health center's encounter rate for services provided
3 to medical assistance recipients that are performed by a
4 dental hygienist, as defined under the Illinois Dental
5 Practice Act, working under the general supervision of a
6 dentist and employed by a federally qualified health center.
7 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
8 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
9 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
10 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
11 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
12 1-1-20; revised 9-18-19.)

13 (305 ILCS 5/5-42 new)
14 Sec. 5-42. Tobacco cessation coverage; managed care.
15 Notwithstanding any other provision of this Article, a managed
16 care organization under contract with the Department to
17 provide services to recipients of medical assistance shall
18 provide coverage for all tobacco cessation medications
19 approved by the United States Food and Drug Administration,
20 all individual and group tobacco cessation counseling
21 services, and all telephone-based counseling services and
22 tobacco cessation medications provided through the Illinois
23 Tobacco Quitline. The Department may adopt any rules necessary
24 to implement this Section.

1 Article 45.

2 Section 45-5. The Illinois Public Aid Code is amended by
3 changing Section 12-4.35 as follows:

4 (305 ILCS 5/12-4.35)
5 Sec. 12-4.35. Medical services for certain noncitizens.
6 (a) Notwithstanding Section 1-11 of this Code or Section
7 20(a) of the Children's Health Insurance Program Act, the
8 Department of Healthcare and Family Services may provide
9 medical services to noncitizens who have not yet attained 19
10 years of age and who are not eligible for medical assistance
11 under Article V of this Code or under the Children's Health
12 Insurance Program created by the Children's Health Insurance
13 Program Act due to their not meeting the otherwise applicable
14 provisions of Section 1-11 of this Code or Section 20(a) of the
15 Children's Health Insurance Program Act. The medical services
16 available, standards for eligibility, and other conditions of
17 participation under this Section shall be established by rule
18 by the Department; however, any such rule shall be at least as
19 restrictive as the rules for medical assistance under Article
20 V of this Code or the Children's Health Insurance Program
21 created by the Children's Health Insurance Program Act.
22 (a-5) Notwithstanding Section 1-11 of this Code, the
23 Department of Healthcare and Family Services may provide
24 medical assistance in accordance with Article V of this Code

1 to noncitizens over the age of 65 years of age who are not
2 eligible for medical assistance under Article V of this Code
3 due to their not meeting the otherwise applicable provisions
4 of Section 1-11 of this Code, whose income is at or below 100%
5 of the federal poverty level after deducting the costs of
6 medical or other remedial care, and who would otherwise meet
7 the eligibility requirements in Section 5-2 of this Code. The
8 medical services available, standards for eligibility, and
9 other conditions of participation under this Section shall be
10 established by rule by the Department; however, any such rule
11 shall be at least as restrictive as the rules for medical
12 assistance under Article V of this Code.

13 (a-10) Notwithstanding the provisions of Section 1-11, the
14 Department shall cover immunosuppressive drugs and related
15 services associated with post-kidney transplant management,
16 excluding long-term care costs, for noncitizens who: (i) are
17 not eligible for comprehensive medical benefits; (ii) meet the
18 residency requirements of Section 5-3; and (iii) would meet
19 the financial eligibility requirements of Section 5-2.

20 (b) The Department is authorized to take any action,
21 including without limitation cessation or limitation of
22 enrollment, reduction of available medical services, and
23 changing standards for eligibility, that is deemed necessary
24 by the Department during a State fiscal year to assure that
25 payments under this Section do not exceed available funds.

26 (c) Continued enrollment of individuals into the program

created under subsection (a) of this Section in any fiscal year is contingent upon continued enrollment of individuals into the Children's Health Insurance Program during that fiscal year.

(d) (Blank).

(Source: P.A. 101-636, eff. 6-10-20.)

Article 55.

Section 55-5. 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

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

discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

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

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

documentation.

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department 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.

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

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

Notwithstanding any other provision of this Code and

1 subject to federal approval, the Department may adopt rules to
2 allow a dentist who is volunteering his or her service at no
3 cost to render dental services through an enrolled
4 not-for-profit health clinic without the dentist personally
5 enrolling as a participating provider in the medical
6 assistance program. A not-for-profit health clinic shall
7 include a public health clinic or Federally Qualified Health
8 Center or other enrolled provider, as determined by the
9 Department, through which dental services covered under this
10 Section are performed. The Department shall establish a
11 process for payment of claims for reimbursement for covered
12 dental services rendered under this provision.

13 The Illinois Department, by rule, may distinguish and
14 classify the medical services to be provided only in
15 accordance with the classes of persons designated in Section
16 5-2.

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

24 The Illinois Department shall authorize the provision of,
25 and shall authorize payment for, screening by low-dose
26 mammography for the presence of occult breast cancer for women

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

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

1 stationary breast to produce cross-sectional digital
2 three-dimensional images of the breast.
3 If, at any time, the Secretary of the United States
4 Department of Health and Human Services, or its successor
5 agency, promulgates rules or regulations to be published in
6 the Federal Register or publishes a comment in the Federal
7 Register or issues an opinion, guidance, or other action that
8 would require the State, pursuant to any provision of the
9 Patient Protection and Affordable Care Act (Public Law
10 111-148), including, but not limited to, 42 U.S.C.
11 18031(d)(3)(B) or any successor provision, to defray the cost
12 of any coverage for breast tomosynthesis outlined in this
13 paragraph, then the requirement that an insurer cover breast
14 tomosynthesis is inoperative other than any such coverage
15 authorized under Section 1902 of the Social Security Act, 42
16 U.S.C. 1396a, and the State shall not assume any obligation
17 for the cost of coverage for breast tomosynthesis set forth in
18 this paragraph.
19 On and after January 1, 2016, the Department shall ensure
20 that all networks of care for adult clients of the Department
21 include access to at least one breast imaging Center of
22 Imaging Excellence as certified by the American College of
23 Radiology.
24 On and after January 1, 2012, providers participating in a
25 quality improvement program approved by the Department shall
26 be reimbursed for screening and diagnostic mammography at the

1 same rate as the Medicare program's rates, including the
2 increased reimbursement for digital mammography.
3 The Department shall convene an expert panel including
4 representatives of hospitals, free-standing mammography
5 facilities, and doctors, including radiologists, to establish
6 quality standards for mammography.
7 On and after January 1, 2017, providers participating in a
8 breast cancer treatment quality improvement program approved
9 by the Department shall be reimbursed for breast cancer
10 treatment at a rate that is no lower than 95% of the Medicare
11 program's rates for the data elements included in the breast
12 cancer treatment quality program.
13 The Department shall convene an expert panel, including
14 representatives of hospitals, free-standing breast cancer
15 treatment centers, breast cancer quality organizations, and
16 doctors, including breast surgeons, reconstructive breast
17 surgeons, oncologists, and primary care providers to establish
18 quality standards for breast cancer treatment.
19 Subject to federal approval, the Department shall
20 establish a rate methodology for mammography at federally
21 qualified health centers and other encounter-rate clinics.
22 These clinics or centers may also collaborate with other
23 hospital-based mammography facilities. By January 1, 2016, the
24 Department shall report to the General Assembly on the status
25 of the provision set forth in this paragraph.
26 The Department shall establish a methodology to remind

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

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

15 The Department shall devise a means of case-managing or
16 patient navigation for beneficiaries diagnosed with breast
17 cancer. This program shall initially operate as a pilot
18 program in areas of the State with the highest incidence of
19 mortality related to breast cancer. At least one pilot program
20 site shall be in the metropolitan Chicago area and at least one
21 site shall be outside the metropolitan Chicago area. On or
22 after July 1, 2016, the pilot program shall be expanded to
23 include one site in western Illinois, one site in southern
24 Illinois, one site in central Illinois, and 4 sites within
25 metropolitan Chicago. An evaluation of the pilot program shall
26 be carried out measuring health outcomes and cost of care for

1 those served by the pilot program compared to similarly
2 situated patients who are not served by the pilot program.
3 The Department shall require all networks of care to
4 develop a means either internally or by contract with experts
5 in navigation and community outreach to navigate cancer
6 patients to comprehensive care in a timely fashion. The
7 Department shall require all networks of care to include
8 access for patients diagnosed with cancer to at least one
9 academic commission on cancer-accredited cancer program as an
10 in-network covered benefit.
11 Any medical or health care provider shall immediately
12 recommend, to any pregnant woman who is being provided
13 prenatal services and is suspected of having a substance use
14 disorder as defined in the Substance Use Disorder Act,
15 referral to a local substance use disorder treatment program
16 licensed by the Department of Human Services or to a licensed
17 hospital which provides substance abuse treatment services.
18 The Department of Healthcare and Family Services shall assure
19 coverage for the cost of treatment of the drug abuse or
20 addiction for pregnant recipients in accordance with the
21 Illinois Medicaid Program in conjunction with the Department
22 of Human Services.
23 All medical providers providing medical assistance to
24 pregnant women under this Code shall receive information from
25 the Department on the availability of services under any
26 program providing case management services for addicted women,

including information on appropriate referrals for other social services that may be needed by addicted women in addition to treatment for addiction.

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

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

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

The Illinois Department may develop and contract with Partnerships of medical providers to arrange medical services for persons eligible under Section 5-2 of this Code.

Implementation of this Section may be by demonstration projects in certain geographic areas. The Partnership shall be represented by a sponsor organization. The Department, by rule, shall develop qualifications for sponsors of Partnerships. Nothing in this Section shall be construed to require that the sponsor organization be a medical organization.

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

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

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

(3) Persons receiving medical services through

Partnerships may receive medical and case management services above the level usually offered through the medical assistance program.

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the delivery of high quality medical services. These qualifications shall be determined by rule of the Illinois 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

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

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

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

25 Notwithstanding any other law to the contrary, the
26 Illinois Department shall, within 365 days after August 15,

2014 (the effective date of Public Act 98-963), establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act and MC/DD facilities licensed under the MC/DD Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

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

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

1 Enrollment of a vendor shall be subject to a provisional
2 period and shall be conditional for one year. During the
3 period of conditional enrollment, the Department may terminate
4 the vendor's eligibility to participate in, or may disenroll
5 the vendor from, the medical assistance program without cause.
6 Unless otherwise specified, such termination of eligibility or
7 disenrollment is not subject to the Department's hearing
8 process. However, a disenrolled vendor may reapply without
9 penalty.
10 The Department has the discretion to limit the conditional
11 enrollment period for vendors based upon category of risk of
12 the vendor.
13 Prior to enrollment and during the conditional enrollment
14 period in the medical assistance program, all vendors shall be
15 subject to enhanced oversight, screening, and review based on
16 the risk of fraud, waste, and abuse that is posed by the
17 category of risk of the vendor. The Illinois Department shall
18 establish the procedures for oversight, screening, and review,
19 which may include, but need not be limited to: criminal and
20 financial background checks; fingerprinting; license,
21 certification, and authorization verifications; unscheduled or
22 unannounced site visits; database checks; prepayment audit
23 reviews; audits; payment caps; payment suspensions; and other
24 screening as required by federal or State law.
25 The Department shall define or specify the following: (i)
26 by provider notice, the "category of risk of the vendor" for

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

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

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

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

(3) In the case of a provider for whom the Illinois

1 Department initiates the monthly billing process.
2 (4) In the case of a provider operated by a unit of
3 local government with a population exceeding 3,000,000
4 when local government funds finance federal participation
5 for claims payments.
6 For claims for services rendered during a period for which
7 a recipient received retroactive eligibility, claims must be
8 filed within 180 days after the Department determines the
9 applicant is eligible. For claims for which the Illinois
10 Department is not the primary payer, claims must be submitted
11 to the Illinois Department within 180 days after the final
12 adjudication by the primary payer.
13 In the case of long term care facilities, within 45
14 calendar days of receipt by the facility of required
15 prescreening information, new admissions with associated
16 admission documents shall be submitted through the Medical
17 Electronic Data Interchange (MEDI) or the Recipient
18 Eligibility Verification (REV) System or shall be submitted
19 directly to the Department of Human Services using required
20 admission forms. Effective September 1, 2014, admission
21 documents, including all prescreening information, must be
22 submitted through MEDI or REV. Confirmation numbers assigned
23 to an accepted transaction shall be retained by a facility to
24 verify timely submittal. Once an admission transaction has
25 been completed, all resubmitted claims following prior
26 rejection are subject to receipt no later than 180 days after

1 the admission transaction has been completed.
2 Claims that are not submitted and received in compliance
3 with the foregoing requirements shall not be eligible for
4 payment under the medical assistance program, and the State
5 shall have no liability for payment of those claims.
6 To the extent consistent with applicable information and
7 privacy, security, and disclosure laws, State and federal
8 agencies and departments shall provide the Illinois Department
9 access to confidential and other information and data
10 necessary to perform eligibility and payment verifications and
11 other Illinois Department functions. This includes, but is not
12 limited to: information pertaining to licensure;
13 certification; earnings; immigration status; citizenship; wage
14 reporting; unearned and earned income; pension income;
15 employment; supplemental security income; social security
16 numbers; National Provider Identifier (NPI) numbers; the
17 National Practitioner Data Bank (NPDB); program and agency
18 exclusions; taxpayer identification numbers; tax delinquency;
19 corporate information; and death records.
20 The Illinois Department shall enter into agreements with
21 State agencies and departments, and is authorized to enter
22 into agreements with federal agencies and departments, under
23 which such agencies and departments shall share data necessary
24 for medical assistance program integrity functions and
25 oversight. The Illinois Department shall develop, in
26 cooperation with other State departments and agencies, and in

compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including, but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

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

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the

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

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

1 must meet the accreditation requirement.
2 In order to promote environmental responsibility, meet the
3 needs of recipients and enrollees, and achieve significant
4 cost savings, the Department, or a managed care organization
5 under contract with the Department, may provide recipients or
6 managed care enrollees who have a prescription or Certificate
7 of Medical Necessity access to refurbished durable medical
8 equipment under this Section (excluding prosthetic and
9 orthotic devices as defined in the Orthotics, Prosthetics, and
10 Pedorthics Practice Act and complex rehabilitation technology
11 products and associated services) through the State's
12 assistive technology program's reutilization program, using
13 staff with the Assistive Technology Professional (ATP)
14 Certification if the refurbished durable medical equipment:
15 (i) is available; (ii) is less expensive, including shipping
16 costs, than new durable medical equipment of the same type;
17 (iii) is able to withstand at least 3 years of use; (iv) is
18 cleaned, disinfected, sterilized, and safe in accordance with
19 federal Food and Drug Administration regulations and guidance
20 governing the reprocessing of medical devices in health care
21 settings; and (v) equally meets the needs of the recipient or
22 enrollee. The reutilization program shall confirm that the
23 recipient or enrollee is not already in receipt of same or
24 similar equipment from another service provider, and that the
25 refurbished durable medical equipment equally meets the needs
26 of the recipient or enrollee. Nothing in this paragraph shall

1 be construed to limit recipient or enrollee choice to obtain
2 new durable medical equipment or place any additional prior
3 authorization conditions on enrollees of managed care
4 organizations.

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

receiving services from the long term care provider. In order to select the minimum level of care eligibility criteria, the Governor shall establish a workgroup that includes affected agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

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

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

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

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

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

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

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

22 A federally qualified health center, as defined in Section
23 1905(l)(2)(B) of the federal Social Security Act, shall be
24 reimbursed by the Department in accordance with the federally
25 qualified health center's encounter rate for services provided
26 to medical assistance recipients that are performed by a

1 dental hygienist, as defined under the Illinois Dental
2 Practice Act, working under the general supervision of a
3 dentist and employed by a federally qualified health center.

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

15 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
16 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
17 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
18 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
19 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
20 1-1-20; revised 9-18-19.)

21 Section 55-10. The All-Inclusive Care for the Elderly Act
22 is amended by changing Sections 1, 15 and 20 by adding Sections
23 6 and 16 as follows:

24 (320 ILCS 40/1) (from Ch. 23, par. 6901)

1 Sec. 1. Short title. This Act may be cited as the Program
2 of All-Inclusive Care for the Elderly Act.
3 (Source: P.A. 87-411.)

4 (320 ILCS 40/6 new)
5 Sec. 6. Definitions. As used in this Act:
6 "Department" means the Department of Healthcare and Family
7 Services.
8 "PACE organization" means an entity as defined in 42 CFR
9 460.6.

10 (320 ILCS 40/15) (from Ch. 23, par. 6915)
11 Sec. 15. Program implementation.
12 (a) The Department of Healthcare and Family Services must
13 prepare and submit a PACE State Plan amendment no later than
14 December 31, 2022 to the federal Centers for Medicare and
15 Medicaid Services to establish the Program of All-Inclusive
16 Care for the Elderly (PACE program) to provide
17 community-based, risk-based, and capitated long-term care
18 services as optional services under the Illinois Title XIX
19 State Plan and under contracts entered into between the
20 federal Centers for Medicare and Medicaid Services, the
21 Department of Healthcare and Family Services, and PACE
22 organizations, meeting the requirements of the Balanced Budget
23 Act of 1997 (Public Law 105-33) and any other applicable law or
24 regulation. ~~Upon receipt of federal approval, the Illinois~~

~~Department of Public Aid (now Department of Healthcare and Family Services) shall implement the PACE program pursuant to the provisions of the approved Title XIX State plan.~~

(b) The Department of Healthcare and Family Services shall facilitate the PACE organization application process no later than December 31, 2023.

(c) All PACE organizations selected shall begin operations no later than June 30, 2024.

(d) ~~(b)~~ Using a risk-based financing model, the organizations contracted to implement ~~nonprofit organization providing~~ the PACE program shall assume responsibility for all costs generated by the PACE program participants, and ~~it~~ shall create and maintain a risk reserve fund that will cover any cost overages for any participant. The PACE program is responsible for the entire range of services in the consolidated service model, including hospital and nursing home care, according to participant need as determined by a multidisciplinary team. The contracted organizations are ~~nonprofit organization providing the PACE program is~~ responsible for the full financial risk. Specific arrangements of the risk-based financing model shall be adopted and negotiated by the federal Centers for Medicare and Medicaid Services, the organizations contracted to implement ~~nonprofit organization providing~~ the PACE program, and the Department of Healthcare and Family Services.

(e) The requirements of the PACE model, as provided for

1 under Section 1894 (42 U.S.C. Sec. 1395eee) and Section 1934
2 (42 U.S.C. Sec. 1396u-4) of the federal Social Security Act,
3 shall not be waived or modified. The requirements that shall
4 not be waived or modified include all of the following:
5 (1) The focus on frail elderly qualifying individuals
6 who require the level of care provided in a nursing
7 facility.
8 (2) The delivery of comprehensive, integrated acute
9 and long-term care services.
10 (3) The interdisciplinary team approach to care
11 management and service delivery.
12 (4) Capitated, integrated financing that allows the
13 provider to pool payments received from public and private
14 programs and individuals.
15 (5) The assumption by the provider of full financial
16 risk.
17 (6) The provision of a PACE benefit package for all
18 participants, regardless of source of payment, that shall
19 include all of the following:
20 (A) All Medicare-covered items and services.
21 (B) All Medicaid-covered items and services, as
22 specified in the Illinois Title XIX State Plan.
23 (C) Other services determined necessary by the
24 interdisciplinary team to improve and maintain the
25 participant's overall health status.
26 (f) The provisions under Sections 1-7 and 5-4 of the

Illinois Public Aid Code and under 80 Ill. Adm. Code 120.379, 120.380, and 120.385 shall apply when determining the eligibility for medical assistance of a person receiving PACE services from an organization providing services under this Act.

(g) Provisions governing the treatment of income and resources of a married couple, for the purposes of determining the eligibility of a nursing-facility certifiable or institutionalized spouse, shall be established so as to qualify for federal financial participation.

(h) Notwithstanding subsection (e), and only to the extent federal financial participation is available, the Department of Healthcare and Family Services, in consultation with PACE organizations, may seek increased federal regulatory flexibility from the federal Centers for Medicare and Medicaid Services to modernize the PACE program, which may include, but is not limited to, addressing all of the following:

(A) Composition of PACE interdisciplinary teams.

(B) Use of community-based physicians.

(C) Marketing practices.

(D) Development of a streamlined PACE waiver process.

This subsection shall be operative upon federal approval of a capitation rate methodology as provided under Section 16.

(i) Each PACE organization shall provide the Department with required reporting documents as set forth in 42 CFR 460.190 through 42 CFR 460.196.

1 (Source: P.A. 94-48, eff. 7-1-05; 95-331, eff. 8-21-07.)

2 (320 ILCS 40/16 new)
3 Sec. 16. Rates of payment.
4 (a) The General Assembly shall make appropriations to the
5 Department to fund services under this Act. The Department
6 shall develop and pay capitation rates to organizations
7 contracted to implement the PACE program as described in
8 Section 15 using actuarial methods.
9 The Department may develop capitation rates using a
10 standardized rate methodology across managed care plan models
11 for comparable populations. The specific rate methodology
12 applied to PACE organizations shall address features of PACE
13 that distinguishes it from other managed care plan models.
14 The rate methodology shall be consistent with actuarial
15 rate development principles and shall provide for all
16 reasonable, appropriate, and attainable costs for each PACE
17 organization within a region.
18 (b) The Department may develop statewide rates and apply
19 geographic adjustments, using available data sources deemed
20 appropriate by the Department. Consistent with actuarial
21 methods, the primary source of data used to develop rates for
22 each PACE organization shall be its cost and utilization data
23 for the Medical Assistance Program or other data sources as
24 deemed necessary by the Department. Rates developed under this
25 Section shall reflect the level of care associated with the

1 specific populations served under the contract.
2 (c) The rate methodology developed in accordance with this
3 Section shall contain a mechanism to account for the costs of
4 high-cost drugs and treatments. Rates developed shall be
5 actuarially certified prior to implementation.
6 (d) Consistent with the requirements of federal law, the
7 Department shall calculate an upper payment limit for payments
8 to PACE organizations. In calculating the upper payment limit,
9 the Department shall collect the applicable data as necessary
10 and shall consider the risk of nursing home placement for the
11 comparable population when estimating the level of care and
12 risk of PACE participants.
13 (e) The Department shall pay organizations contracted to
14 implement the PACE program at a rate within the certified
15 actuarially sound rate range developed with respect to that
16 entity as necessary to mitigate the impact to the entity of the
17 methodology developed in accordance with this Section.
18 (f) This Section shall apply for rates established no
19 earlier than July 1, 2022.

20 (320 ILCS 40/20) (from Ch. 23, par. 6920)
21 Sec. 20. Duties of the Department of Healthcare and Family
22 Services.
23 (a) The Department of Healthcare and Family Services shall
24 provide a system for reimbursement for services to the PACE
25 program.

1 (b) The Department of Healthcare and Family Services shall
2 develop and implement contracts ~~a contract~~ with organizations
3 as provided in subsection (d) of Section 15 that set ~~the~~
4 ~~nonprofit organization providing the PACE program that sets~~
5 forth contractual obligations for the PACE program, including,
6 but not limited to, reporting and monitoring of utilization of
7 costs of the program as required by the Illinois Department.
8 (c) The Department of Healthcare and Family Services shall
9 acknowledge that it is participating in the national PACE
10 project as initiated by Congress.
11 (d) The Department of Healthcare and Family Services or
12 its designee shall be responsible for certifying the
13 eligibility for services of all PACE program participants.
14 (Source: P.A. 95-331, eff. 8-21-07.)

15 (320 ILCS 40/30 rep.)
16 Section 55-15. The All-Inclusive Care for the Elderly Act
17 is amended by repealing Section 30.

18 Article 65.

19 Section 65-5. The Illinois Public Aid Code is amended by
20 changing Section 5-19 as follows:

21 (305 ILCS 5/5-19) (from Ch. 23, par. 5-19)
22 Sec. 5-19. Healthy Kids Program.

(a) Any child under the age of 21 eligible to receive Medical Assistance from the Illinois Department under Article V of this Code shall be eligible for Early and Periodic Screening, Diagnosis and Treatment services provided by the Healthy Kids Program of the Illinois Department under the Social Security Act, 42 U.S.C. 1396d(r).

(b) Enrollment of Children in Medicaid. The Illinois Department shall provide for receipt and initial processing of applications for Medical Assistance for all pregnant women and children under the age of 21 at locations in addition to those used for processing applications for cash assistance, including disproportionate share hospitals, federally qualified health centers and other sites as selected by the Illinois Department.

(c) Healthy Kids Examinations. The Illinois Department shall consider any examination of a child eligible for the Healthy Kids services provided by a medical provider meeting the requirements and complying with the rules and regulations of the Illinois Department to be reimbursed as a Healthy Kids examination.

(d) Medical Screening Examinations.

(1) The Illinois Department shall insure Medicaid coverage for periodic health, vision, hearing, and dental screenings for children eligible for Healthy Kids services scheduled from a child's birth up until the child turns 21 years. The Illinois Department shall pay for vision,

1 hearing, dental and health screening examinations for any
2 child eligible for Healthy Kids services by qualified
3 providers at intervals established by Department rules.
4 (2) The Illinois Department shall pay for an
5 interperiodic health, vision, hearing, or dental screening
6 examination for any child eligible for Healthy Kids
7 services whenever an examination is:
8 (A) requested by a child's parent, guardian, or
9 custodian, or is determined to be necessary or
10 appropriate by social services, developmental, health,
11 or educational personnel; or
12 (B) necessary for enrollment in school; or
13 (C) necessary for enrollment in a licensed day
14 care program, including Head Start; or
15 (D) necessary for placement in a licensed child
16 welfare facility, including a foster home, group home
17 or child care institution; or
18 (E) necessary for attendance at a camping program;
19 or
20 (F) necessary for participation in an organized
21 athletic program; or
22 (G) necessary for enrollment in an early childhood
23 education program recognized by the Illinois State
24 Board of Education; or
25 (H) necessary for participation in a Women,
26 Infant, and Children (WIC) program; or

(I) deemed appropriate by the Illinois Department.

(e) Minimum Screening Protocols For Periodic Health Screening Examinations. Health Screening Examinations must include the following services:

(1) Comprehensive Health and Development Assessment including:

(A) Development/Mental Health/Psychosocial Assessment; and

(B) Assessment of nutritional status including tests for iron deficiency and anemia for children at the following ages: 9 months, 2 years, 8 years, and 18 years;

(2) Comprehensive unclothed physical exam;

(3) Appropriate immunizations at a minimum, as required by the Secretary of the U.S. Department of Health and Human Services under 42 U.S.C. 1396d(r).

(4) Appropriate laboratory tests including blood lead levels appropriate for age and risk factors.

(A) Anemia test.

(B) Sickle cell test.

(C) Tuberculin test at 12 months of age and every 1-2 years thereafter unless the treating health care professional determines that testing is medically contraindicated.

(D) Other -- The Illinois Department shall insure that testing for HIV, drug exposure, and sexually

1 transmitted diseases is provided for as clinically
2 indicated.
3 (5) Health Education. The Illinois Department shall
4 require providers to provide anticipatory guidance as
5 recommended by the American Academy of Pediatrics.
6 (6) Vision Screening. The Illinois Department shall
7 require providers to provide vision screenings consistent
8 with those set forth in the Department of Public Health's
9 Administrative Rules.
10 (7) Hearing Screening. The Illinois Department shall
11 require providers to provide hearing screenings consistent
12 with those set forth in the Department of Public Health's
13 Administrative Rules.
14 (8) Dental Screening. The Illinois Department shall
15 require providers to provide dental screenings consistent
16 with those set forth in the Department of Public Health's
17 Administrative Rules.
18 (f) Covered Medical Services. The Illinois Department
19 shall provide coverage for all necessary health care,
20 diagnostic services, treatment and other measures to correct
21 or ameliorate defects, physical and mental illnesses, and
22 conditions whether discovered by the screening services or not
23 for all children eligible for Medical Assistance under Article
24 V of this Code.
25 (g) Notice of Healthy Kids Services.
26 (1) The Illinois Department shall inform any child

eligible for Healthy Kids services and the child's family about the benefits provided under the Healthy Kids Program, including, but not limited to, the following: what services are available under Healthy Kids, including discussion of the periodicity schedules and immunization schedules, that services are provided at no cost to eligible children, the benefits of preventive health care, where the services are available, how to obtain them, and that necessary transportation and scheduling assistance is available.

(2) The Illinois Department shall widely disseminate information regarding the availability of the Healthy Kids Program throughout the State by outreach activities which shall include, but not be limited to, (i) the development of cooperation agreements with local school districts, public health agencies, clinics, hospitals and other health care providers, including developmental disability and mental health providers, and with charities, to notify the constituents of each of the Program and assist individuals, as feasible, with applying for the Program, (ii) using the media for public service announcements and advertisements of the Program, and (iii) developing posters advertising the Program for display in hospital and clinic waiting rooms.

(3) The Illinois Department shall utilize accepted methods for informing persons who are illiterate, blind,

deaf, or cannot understand the English language, including but not limited to public services announcements and advertisements in the foreign language media of radio, television and newspapers.

(4) The Illinois Department shall provide notice of the Healthy Kids Program to every child eligible for Healthy Kids services and his or her family at the following times:

(A) orally by the intake worker and in writing at the time of application for Medical Assistance;

(B) at the time the applicant is informed that he or she is eligible for Medical Assistance benefits; and

(C) at least 20 days before the date of any periodic health, vision, hearing, and dental examination for any child eligible for Healthy Kids services. Notice given under this subparagraph (C) must state that a screening examination is due under the periodicity schedules and must advise the eligible child and his or her family that the Illinois Department will provide assistance in scheduling an appointment and arranging medical transportation.

(h) Data Collection. The Illinois Department shall collect data in a usable form to track utilization of Healthy Kids screening examinations by children eligible for Healthy Kids services, including but not limited to data showing screening

examinations and immunizations received, a summary of follow-up treatment received by children eligible for Healthy Kids services and the number of children receiving dental, hearing and vision services.

(i) 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.

(j) To ensure full access to the benefits set forth in this Section, on and after January 1, 2022, the Illinois Department shall ensure that provider and hospital reimbursements for immunization as required under this Section are no lower than 70% of the median regional maximum administration fee for the State of Illinois as established by the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services.

(Source: P.A. 97-689, eff. 6-14-12.)

Article 70.

Section 70-5. The Illinois Public Aid Code is amended by changing Section 5-5.01a as follows:

(305 ILCS 5/5-5.01a)

Sec. 5-5.01a. Supportive living facilities program.

1 (a) The Department shall establish and provide oversight
2 for a program of supportive living facilities that seek to
3 promote resident independence, dignity, respect, and
4 well-being in the most cost-effective manner.
5 A supportive living facility is (i) a free-standing
6 facility or (ii) a distinct physical and operational entity
7 within a mixed-use building that meets the criteria
8 established in subsection (d). A supportive living facility
9 integrates housing with health, personal care, and supportive
10 services and is a designated setting that offers residents
11 their own separate, private, and distinct living units.
12 Sites for the operation of the program shall be selected
13 by the Department based upon criteria that may include the
14 need for services in a geographic area, the availability of
15 funding, and the site's ability to meet the standards.
16 (b) Beginning July 1, 2014, subject to federal approval,
17 the Medicaid rates for supportive living facilities shall be
18 equal to the supportive living facility Medicaid rate
19 effective on June 30, 2014 increased by 8.85%. Once the
20 assessment imposed at Article V-G of this Code is determined
21 to be a permissible tax under Title XIX of the Social Security
22 Act, the Department shall increase the Medicaid rates for
23 supportive living facilities effective on July 1, 2014 by
24 9.09%. The Department shall apply this increase retroactively
25 to coincide with the imposition of the assessment in Article
26 V-G of this Code in accordance with the approval for federal

financial participation by the Centers for Medicare and Medicaid Services.

The Medicaid rates for supportive living facilities effective on July 1, 2017 must be equal to the rates in effect for supportive living facilities on June 30, 2017 increased by 2.8%.

Subject to federal approval, the Medicaid rates for supportive living services on and after July 1, 2019 must be at least 54.3% of the average total nursing facility services per diem for the geographic areas defined by the Department while maintaining the rate differential for dementia care and must be updated whenever the total nursing facility service per diems are updated.

(c) The Department may adopt rules to implement this Section. Rules that establish or modify the services, standards, and conditions for participation in the program shall be adopted by the Department in consultation with the Department on Aging, the Department of Rehabilitation Services, and the Department of Mental Health and Developmental Disabilities (or their successor agencies).

(d) Subject to federal approval by the Centers for Medicare and Medicaid Services, the Department shall accept for consideration of certification under the program any application for a site or building where distinct parts of the site or building are designated for purposes other than the provision of supportive living services, but only if:

1 (1) those distinct parts of the site or building are
2 not designated for the purpose of providing assisted
3 living services as required under the Assisted Living and
4 Shared Housing Act;
5 (2) those distinct parts of the site or building are
6 completely separate from the part of the building used for
7 the provision of supportive living program services,
8 including separate entrances;
9 (3) those distinct parts of the site or building do
10 not share any common spaces with the part of the building
11 used for the provision of supportive living program
12 services; and
13 (4) those distinct parts of the site or building do
14 not share staffing with the part of the building used for
15 the provision of supportive living program services.
16 (e) Facilities or distinct parts of facilities which are
17 selected as supportive living facilities and are in good
18 standing with the Department's rules are exempt from the
19 provisions of the Nursing Home Care Act and the Illinois
20 Health Facilities Planning Act.
21 (f) Section 9817 of the American Rescue Plan Act of 2021
22 (Public Law 117-2) authorizes a 10% enhanced federal medical
23 assistance percentage for supportive living services for a
24 12-month period from April 1, 2021 through March 31, 2022.
25 Subject to federal approval, including the approval of any
26 necessary waiver amendments or other federally required

documents or assurances, for a 12-month period the Department must pay a supplemental $26 per diem rate to all supportive living facilities with the additional federal financial participation funds that result from the enhanced federal medical assistance percentage from April 1, 2021 through March 31, 2022. The Department may issue parameters around how the supplemental payment should be spent, including quality improvement activities. The Department may alter the form, methods, or timeframes concerning the supplemental per diem rate to comply with any subsequent changes to federal law, changes made by guidance issued by the federal Centers for Medicare and Medicaid Services, or other changes necessary to receive the enhanced federal medical assistance percentage.
(Source: P.A. 100-23, eff. 7-6-17; 100-583, eff. 4-6-18; 100-587, eff. 6-4-18; 101-10, eff. 6-5-19.)

Article 75.

Section 75-5. The Illinois Health Information Exchange and Technology Act is amended by adding Section 997 as follows:

(20 ILCS 3860/997 new)
Sec. 997. Repealer. This Act is repealed on January 1, 2027.

Article 80.

1 Section 80-5. The Illinois Public Aid Code is amended by
2 changing Section 5-5f as follows:

3 (305 ILCS 5/5-5f)
4 Sec. 5-5f. Elimination and limitations of medical
5 assistance services. Notwithstanding any other provision of
6 this Code to the contrary, on and after July 1, 2012:
7 (a) The following services shall no longer be a
8 covered service available under this Code: group
9 psychotherapy for residents of any facility licensed under
10 the Nursing Home Care Act or the Specialized Mental Health
11 Rehabilitation Act of 2013; and adult chiropractic
12 services.
13 (b) The Department shall place the following
14 limitations on services: (i) the Department shall limit
15 adult eyeglasses to one pair every 2 years; however, the
16 limitation does not apply to an individual who needs
17 different eyeglasses following a surgical procedure such
18 as cataract surgery; (ii) the Department shall set an
19 annual limit of a maximum of 20 visits for each of the
20 following services: adult speech, hearing, and language
21 therapy services, adult occupational therapy services, and
22 physical therapy services; on or after October 1, 2014,
23 the annual maximum limit of 20 visits shall expire but the
24 Department may require prior approval for all individuals

1 for speech, hearing, and language therapy services,
2 occupational therapy services, and physical therapy
3 services; (iii) the Department shall limit adult podiatry
4 services to individuals with diabetes; on or after October
5 1, 2014, podiatry services shall not be limited to
6 individuals with diabetes; (iv) the Department shall pay
7 for caesarean sections at the normal vaginal delivery rate
8 unless a caesarean section was medically necessary; (v)
9 the Department shall limit adult dental services to
10 emergencies; beginning July 1, 2013, the Department shall
11 ensure that the following conditions are recognized as
12 emergencies: (A) dental services necessary for an
13 individual in order for the individual to be cleared for a
14 medical procedure, such as a transplant; (B) extractions
15 and dentures necessary for a diabetic to receive proper
16 nutrition; (C) extractions and dentures necessary as a
17 result of cancer treatment; and (D) dental services
18 necessary for the health of a pregnant woman prior to
19 delivery of her baby; on or after July 1, 2014, adult
20 dental services shall no longer be limited to emergencies,
21 and dental services necessary for the health of a pregnant
22 woman prior to delivery of her baby shall continue to be
23 covered; and (vi) effective July 1, 2012, the Department
24 shall place limitations and require concurrent review on
25 every inpatient detoxification stay to prevent repeat
26 admissions to any hospital for detoxification within 60

days of a previous inpatient detoxification stay. The Department shall convene a workgroup of hospitals, substance abuse providers, care coordination entities, managed care plans, and other stakeholders to develop recommendations for quality standards, diversion to other settings, and admission criteria for patients who need inpatient detoxification, which shall be published on the Department's website no later than September 1, 2013.

(c) The Department shall require prior approval of the following services: wheelchair repairs costing more than $750 ~~$400~~, coronary artery bypass graft, and bariatric surgery consistent with Medicare standards concerning patient responsibility. Wheelchair repair prior approval requests shall be adjudicated within one business day of receipt of complete supporting documentation. Providers may not break wheelchair repairs into separate claims for purposes of staying under the $750 ~~$400~~ threshold for requiring prior approval. The wholesale price of manual and power wheelchairs, durable medical equipment and supplies, and complex rehabilitation technology products and services shall be defined as actual acquisition cost including all discounts.

(d) The Department shall establish benchmarks for hospitals to measure and align payments to reduce potentially preventable hospital readmissions, inpatient complications, and unnecessary emergency room visits. In

doing so, the Department shall consider items, including, but not limited to, historic and current acuity of care and historic and current trends in readmission. The Department shall publish provider-specific historical readmission data and anticipated potentially preventable targets 60 days prior to the start of the program. In the instance of readmissions, the Department shall adopt policies and rates of reimbursement for services and other payments provided under this Code to ensure that, by June 30, 2013, expenditures to hospitals are reduced by, at a minimum, $40,000,000.

(e) The Department shall establish utilization controls for the hospice program such that it shall not pay for other care services when an individual is in hospice.

(f) For home health services, the Department shall require Medicare certification of providers participating in the program and implement the Medicare face-to-face encounter rule. The Department shall require providers to implement auditable electronic service verification based on global positioning systems or other cost-effective technology.

(g) For the Home Services Program operated by the Department of Human Services and the Community Care Program operated by the Department on Aging, the Department of Human Services, in cooperation with the

Department on Aging, shall implement an electronic service verification based on global positioning systems or other cost-effective technology.

(h) Effective with inpatient hospital admissions on or after July 1, 2012, the Department shall reduce the payment for a claim that indicates the occurrence of a provider-preventable condition during the admission as specified by the Department in rules. The Department shall not pay for services related to an other provider-preventable condition.

As used in this subsection (h):

"Provider-preventable condition" means a health care acquired condition as defined under the federal Medicaid regulation found at 42 CFR 447.26 or an other provider-preventable condition.

"Other provider-preventable condition" means a wrong surgical or other invasive procedure performed on a patient, a surgical or other invasive procedure performed on the wrong body part, or a surgical procedure or other invasive procedure performed on the wrong patient.

(i) The Department shall implement cost savings initiatives for advanced imaging services, cardiac imaging services, pain management services, and back surgery. Such initiatives shall be designed to achieve annual costs savings.

(j) The Department shall ensure that beneficiaries

with a diagnosis of epilepsy or seizure disorder in Department records will not require prior approval for anticonvulsants.

(Source: P.A. 100-135, eff. 8-18-17; 101-209, eff. 8-5-19.)

Article 85.

Section 85-5. The School Code is amended by changing Section 14-15.01 as follows:

(105 ILCS 5/14-15.01) (from Ch. 122, par. 14-15.01)

Sec. 14-15.01. Community and Residential Services Authority.

(a) (1) The Community and Residential Services Authority is hereby created and shall consist of the following members:

A representative of the State Board of Education;

Four representatives of the Department of Human Services appointed by the Secretary of Human Services, with one member from the Division of Community Health and Prevention, one member from the Division of Developmental Disabilities, one member from the Division of Mental Health, and one member from the Division of Rehabilitation Services;

A representative of the Department of Children and Family Services;

A representative of the Department of Juvenile Justice;

A representative of the Department of Healthcare and

1 Family Services;
2 A representative of the Attorney General's Disability
3 Rights Advocacy Division;
4 The Chairperson and Minority Spokesperson of the House and
5 Senate Committees on Elementary and Secondary Education or
6 their designees; and
7 Six persons appointed by the Governor. Five of such
8 appointees shall be experienced or knowledgeable relative to
9 provision of services for individuals with a behavior disorder
10 or a severe emotional disturbance and shall include
11 representatives of both the private and public sectors, except
12 that no more than 2 of those 5 appointees may be from the
13 public sector and at least 2 must be or have been directly
14 involved in provision of services to such individuals. The
15 remaining member appointed by the Governor shall be or shall
16 have been a parent of an individual with a behavior disorder or
17 a severe emotional disturbance, and that appointee may be from
18 either the private or the public sector.
19 (2) Members appointed by the Governor shall be appointed
20 for terms of 4 years and shall continue to serve until their
21 respective successors are appointed; provided that the terms
22 of the original appointees shall expire on August 1, 1990. Any
23 vacancy in the office of a member appointed by the Governor
24 shall be filled by appointment of the Governor for the
25 remainder of the term.
26 A vacancy in the office of a member appointed by the

Governor exists when one or more of the following events occur:

(i) An appointee dies;

(ii) An appointee files a written resignation with the Governor;

(iii) An appointee ceases to be a legal resident of the State of Illinois; or

(iv) An appointee fails to attend a majority of regularly scheduled Authority meetings in a fiscal year.

Members who are representatives of an agency shall serve at the will of the agency head. Membership on the Authority shall cease immediately upon cessation of their affiliation with the agency. If such a vacancy occurs, the appropriate agency head shall appoint another person to represent the agency.

If a legislative member of the Authority ceases to be Chairperson or Minority Spokesperson of the designated Committees, they shall automatically be replaced on the Authority by the person who assumes the position of Chairperson or Minority Spokesperson.

(b) The Community and Residential Services Authority shall have the following powers and duties:

(1) To conduct surveys to determine the extent of need, the degree to which documented need is currently being met and feasible alternatives for matching need with resources.

(2) To develop policy statements for interagency cooperation to cover all aspects of service delivery, including laws, regulations and procedures, and clear guidelines for determining responsibility at all times.

(3) To recommend policy statements and provide information regarding effective programs for delivery of services to all individuals under 22 years of age with a behavior disorder or a severe emotional disturbance in public or private situations.

(4) To review the criteria for service eligibility, provision and availability established by the governmental agencies represented on this Authority, and to recommend changes, additions or deletions to such criteria.

(5) To develop and submit to the Governor, the General Assembly, the Directors of the agencies represented on the Authority, and the State Board of Education a master plan for individuals under 22 years of age with a behavior disorder or a severe emotional disturbance, including detailed plans of service ranging from the least to the most restrictive options; and to assist local communities, upon request, in developing or strengthening collaborative interagency networks.

(6) To develop a process for making determinations in situations where there is a dispute relative to a plan of service for individuals or funding for a plan of service.

(7) To provide technical assistance to parents,

service consumers, providers, and member agency personnel regarding statutory responsibilities of human service and educational agencies, and to provide such assistance as deemed necessary to appropriately access needed services.

(8) To establish a pilot program to act as a residential research hub to research and identify appropriate residential settings for youth who are being housed in an emergency room for more than 72 hours or who are deemed beyond medical necessity in a psychiatric hospital. If a child is deemed beyond medical necessity in a psychiatric hospital and is in need of residential placement, the goal of the program is to prevent a lock-out pursuant to the goals of the Custody Relinquishment Prevention Act.

(c) (1) The members of the Authority shall receive no compensation for their services but shall be entitled to reimbursement of reasonable expenses incurred while performing their duties.

(2) The Authority may appoint special study groups to operate under the direction of the Authority and persons appointed to such groups shall receive only reimbursement of reasonable expenses incurred in the performance of their duties.

(3) The Authority shall elect from its membership a chairperson, vice-chairperson and secretary.

(4) The Authority may employ and fix the compensation of

such employees and technical assistants as it deems necessary to carry out its powers and duties under this Act. Staff assistance for the Authority shall be provided by the State Board of Education.

(5) Funds for the ordinary and contingent expenses of the Authority shall be appropriated to the State Board of Education in a separate line item.

(d) (1) The Authority shall have power to promulgate rules and regulations to carry out its powers and duties under this Act.

(2) The Authority may accept monetary gifts or grants from the federal government or any agency thereof, from any charitable foundation or professional association or from any other reputable source for implementation of any program necessary or desirable to the carrying out of the general purposes of the Authority. Such gifts and grants may be held in trust by the Authority and expended in the exercise of its powers and performance of its duties as prescribed by law.

(3) The Authority shall submit an annual report of its activities and expenditures to the Governor, the General Assembly, the directors of agencies represented on the Authority, and the State Superintendent of Education.

(e) The Executive Director of the Authority or his or her designee shall be added as a participant on the Interagency Clinical Team established in the intergovernmental agreement among the Department of Healthcare and Family Services, the

Department of Children and Family Services, the Department of Human Services, the State Board of Education, the Department of Juvenile Justice, and the Department of Public Health, with consent of the youth or the youth's guardian or family pursuant to the Custody Relinquishment Prevention Act.

(Source: P.A. 95-331, eff. 8-21-07; 95-793, eff. 1-1-09.)

Article 90.

Section 90-5. The Illinois Public Aid Code is amended by adding Section 5-43 as follows:

(305 ILCS 5/5-43 new)

Sec. 5-43. Supports Waiver Program for Young Adults with Developmental Disabilities.

(a) The Department of Human Services' Division of Developmental Disabilities, in partnership with the Department of Healthcare and Family Services and stakeholders, shall study the development and implementation of a supports waiver program for young adults with developmental disabilities. The Division shall explore the following components of a supports waiver program to determine what is most appropriate:

(1) The age of individuals to be provided services in a waiver program.

(2) The number of individuals to be provided services in a waiver program.

1 (3) The services to be provided in a waiver program.
2 (4) The funding to be provided to individuals within a
3 waiver program.
4 (5) The transition process to the Waiver for Adults
5 with Developmental Disabilities.
6 (6) The type of home and community-based services
7 waiver to be utilized.
8 (b) The Department of Human Services and the Department of
9 Healthcare and Family Services are authorized to adopt and
10 implement any rules necessary to study the supports waiver
11 program.
12 (c) Subject to appropriation, no later than January 1,
13 2024, the Department of Healthcare and Family Services shall
14 apply to the federal Centers for Medicare and Medicaid
15 Services for a supports waiver for young adults with
16 developmental disabilities utilizing the information learned
17 from the study under subsection (a).

18 Article 95.

19 Section 95-5. The Illinois Public Aid Code is amended by
20 adding Section 5-5.06a as follows:

21 (305 ILCS 5/5-5.06a new)
22 Sec. 5-5.06a. Increased funding for dental services.
23 Beginning January 1, 2022, the amount allocated to fund rates

1 for dental services provided to adults and children under the
2 medical assistance program shall be increased by an
3 approximate amount of $10,000,000.

4 Article 100.

5 Section 100-5. The Illinois Public Aid Code is amended by
6 changing Section 5-5 as follows:

7 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
8 Sec. 5-5. Medical services. The Illinois Department, by
9 rule, shall determine the quantity and quality of and the rate
10 of reimbursement for the medical assistance for which payment
11 will be authorized, and the medical services to be provided,
12 which may include all or part of the following: (1) inpatient
13 hospital services; (2) outpatient hospital services; (3) other
14 laboratory and X-ray services; (4) skilled nursing home
15 services; (5) physicians' services whether furnished in the
16 office, the patient's home, a hospital, a skilled nursing
17 home, or elsewhere; (6) medical care, or any other type of
18 remedial care furnished by licensed practitioners; (7) home
19 health care services; (8) private duty nursing service; (9)
20 clinic services; (10) dental services, including prevention
21 and treatment of periodontal disease and dental caries disease
22 for pregnant women, provided by an individual licensed to
23 practice dentistry or dental surgery; for purposes of this

1 item (10), "dental services" means diagnostic, preventive, or
2 corrective procedures provided by or under the supervision of
3 a dentist in the practice of his or her profession; (11)
4 physical therapy and related services; (12) prescribed drugs,
5 dentures, and prosthetic devices; and eyeglasses prescribed by
6 a physician skilled in the diseases of the eye, or by an
7 optometrist, whichever the person may select; (13) other
8 diagnostic, screening, preventive, and rehabilitative
9 services, including to ensure that the individual's need for
10 intervention or treatment of mental disorders or substance use
11 disorders or co-occurring mental health and substance use
12 disorders is determined using a uniform screening, assessment,
13 and evaluation process inclusive of criteria, for children and
14 adults; for purposes of this item (13), a uniform screening,
15 assessment, and evaluation process refers to a process that
16 includes an appropriate evaluation and, as warranted, a
17 referral; "uniform" does not mean the use of a singular
18 instrument, tool, or process that all must utilize; (14)
19 transportation and such other expenses as may be necessary;
20 (15) medical treatment of sexual assault survivors, as defined
21 in Section 1a of the Sexual Assault Survivors Emergency
22 Treatment Act, for injuries sustained as a result of the
23 sexual assault, including examinations and laboratory tests to
24 discover evidence which may be used in criminal proceedings
25 arising from the sexual assault; (16) the diagnosis and
26 treatment of sickle cell anemia; and (17) any other medical

1 care, and any other type of remedial care recognized under the
2 laws of this State. The term "any other type of remedial care"
3 shall include nursing care and nursing home service for
4 persons who rely on treatment by spiritual means alone through
5 prayer for healing.

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

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

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

25 Upon receipt of federal approval of an amendment to the
26 Illinois Title XIX State Plan for this purpose, the Department

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

1 the person may select.
2 On and after July 1, 2018, the Department of Healthcare
3 and Family Services shall provide dental services to any adult
4 who is otherwise eligible for assistance under the medical
5 assistance program. As used in this paragraph, "dental
6 services" means diagnostic, preventative, restorative, or
7 corrective procedures, including procedures and services for
8 the prevention and treatment of periodontal disease and dental
9 caries disease, provided by an individual who is licensed to
10 practice dentistry or dental surgery or who is under the
11 supervision of a dentist in the practice of his or her
12 profession.
13 On and after July 1, 2018, targeted dental services, as
14 set forth in Exhibit D of the Consent Decree entered by the
15 United States District Court for the Northern District of
16 Illinois, Eastern Division, in the matter of Memisovski v.
17 Maram, Case No. 92 C 1982, that are provided to adults under
18 the medical assistance program shall be established at no less
19 than the rates set forth in the "New Rate" column in Exhibit D
20 of the Consent Decree for targeted dental services that are
21 provided to persons under the age of 18 under the medical
22 assistance program.
23 Notwithstanding any other provision of this Code and
24 subject to federal approval, the Department may adopt rules to
25 allow a dentist who is volunteering his or her service at no
26 cost to render dental services through an enrolled

not-for-profit health clinic without the dentist personally enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

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

1 pursuant to Section 223 of the Internal Revenue Code (26
2 U.S.C. 223).
3 All screenings shall include a physical breast exam,
4 instruction on self-examination and information regarding the
5 frequency of self-examination and its value as a preventative
6 tool.
7 For purposes of this Section:
8 "Diagnostic mammogram" means a mammogram obtained using
9 diagnostic mammography.
10 "Diagnostic mammography" means a method of screening that
11 is designed to evaluate an abnormality in a breast, including
12 an abnormality seen or suspected on a screening mammogram or a
13 subjective or objective abnormality otherwise detected in the
14 breast.
15 "Low-dose mammography" means the x-ray examination of the
16 breast using equipment dedicated specifically for mammography,
17 including the x-ray tube, filter, compression device, and
18 image receptor, with an average radiation exposure delivery of
19 less than one rad per breast for 2 views of an average size
20 breast. The term also includes digital mammography and
21 includes breast tomosynthesis.
22 "Breast tomosynthesis" means a radiologic procedure that
23 involves the acquisition of projection images over the
24 stationary breast to produce cross-sectional digital
25 three-dimensional images of the breast.
26 If, at any time, the Secretary of the United States

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

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

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

The Department shall convene an expert panel including

1 representatives of hospitals, free-standing mammography
2 facilities, and doctors, including radiologists, to establish
3 quality standards for mammography.

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

10 The Department shall convene an expert panel, including
11 representatives of hospitals, free-standing breast cancer
12 treatment centers, breast cancer quality organizations, and
13 doctors, including breast surgeons, reconstructive breast
14 surgeons, oncologists, and primary care providers to establish
15 quality standards for breast cancer treatment.

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

23 The Department shall establish a methodology to remind
24 women who are age-appropriate for screening mammography, but
25 who have not received a mammogram within the previous 18
26 months, of the importance and benefit of screening

mammography. The Department shall work with experts in breast cancer outreach and patient navigation to optimize these reminders and shall establish a methodology for evaluating their effectiveness and modifying the methodology based on the evaluation.

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

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

The Department shall require all networks of care to

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

Any medical or health care provider shall immediately recommend, to any pregnant woman who is being provided prenatal services and is suspected of having a substance use disorder as defined in the Substance Use Disorder Act, referral to a local substance use disorder treatment program licensed by the Department of Human Services or to a licensed hospital which provides substance abuse treatment services. The Department of Healthcare and Family Services shall assure coverage for the cost of treatment of the drug abuse or addiction for pregnant recipients in accordance with the Illinois Medicaid Program in conjunction with the Department of Human Services.

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

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

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

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

21 The Illinois Department may develop and contract with
22 Partnerships of medical providers to arrange medical services
23 for persons eligible under Section 5-2 of this Code.
24 Implementation of this Section may be by demonstration
25 projects in certain geographic areas. The Partnership shall be
26 represented by a sponsor organization. The Department, by

1 rule, shall develop qualifications for sponsors of
2 Partnerships. Nothing in this Section shall be construed to
3 require that the sponsor organization be a medical
4 organization.

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

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

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

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

1 Medical providers shall be required to meet certain
2 qualifications to participate in Partnerships to ensure the
3 delivery of high quality medical services. These
4 qualifications shall be determined by rule of the Illinois
5 Department and may be higher than qualifications for
6 participation in the medical assistance program. Partnership
7 sponsors may prescribe reasonable additional qualifications
8 for participation by medical providers, only with the prior
9 written approval of the Illinois Department.
10 Nothing in this Section shall limit the free choice of
11 practitioners, hospitals, and other providers of medical
12 services by clients. In order to ensure patient freedom of
13 choice, the Illinois Department shall immediately promulgate
14 all rules and take all other necessary actions so that
15 provided services may be accessed from therapeutically
16 certified optometrists to the full extent of the Illinois
17 Optometric Practice Act of 1987 without discriminating between
18 service providers.
19 The Department shall apply for a waiver from the United
20 States Health Care Financing Administration to allow for the
21 implementation of Partnerships under this Section.
22 The Illinois Department shall require health care
23 providers to maintain records that document the medical care
24 and services provided to recipients of Medical Assistance
25 under this Article. Such records must be retained for a period
26 of not less than 6 years from the date of service or as

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

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

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

22 Notwithstanding any other law to the contrary, the
23 Illinois Department shall, within 365 days after August 15,
24 2014 (the effective date of Public Act 98-963), establish
25 procedures to permit ID/DD facilities licensed under the ID/DD
26 Community Care Act and MC/DD facilities licensed under the

MC/DD Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

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

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

Enrollment of a vendor shall be subject to a provisional period and shall be conditional for one year. During the period of conditional enrollment, the Department may terminate

1 the vendor's eligibility to participate in, or may disenroll
2 the vendor from, the medical assistance program without cause.
3 Unless otherwise specified, such termination of eligibility or
4 disenrollment is not subject to the Department's hearing
5 process. However, a disenrolled vendor may reapply without
6 penalty.

7 The Department has the discretion to limit the conditional
8 enrollment period for vendors based upon category of risk of
9 the vendor.

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

22 The Department shall define or specify the following: (i)
23 by provider notice, the "category of risk of the vendor" for
24 each type of vendor, which shall take into account the level of
25 screening applicable to a particular category of vendor under
26 federal law and regulations; (ii) by rule or provider notice,

the maximum length of the conditional enrollment period for each category of risk of the vendor; and (iii) by rule, the hearing rights, if any, afforded to a vendor in each category of risk of the vendor that is terminated or disenrolled during the conditional enrollment period.

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

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

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

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

(4) In the case of a provider operated by a unit of local government with a population exceeding 3,000,000

when local government funds finance federal participation for claims payments.

(5) In cases established by Department rule.

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

In the case of long term care facilities, within 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

1 with the foregoing requirements shall not be eligible for
2 payment under the medical assistance program, and the State
3 shall have no liability for payment of those claims.

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

18 The Illinois Department shall enter into agreements with
19 State agencies and departments, and is authorized to enter
20 into agreements with federal agencies and departments, under
21 which such agencies and departments shall share data necessary
22 for medical assistance program integrity functions and
23 oversight. The Illinois Department shall develop, in
24 cooperation with other State departments and agencies, and in
25 compliance with applicable federal laws and regulations,
26 appropriate and effective methods to share such data. At a

1 minimum, and to the extent necessary to provide data sharing,
2 the Illinois Department shall enter into agreements with State
3 agencies and departments, and is authorized to enter into
4 agreements with federal agencies and departments, including,
5 but not limited to: the Secretary of State; the Department of
6 Revenue; the Department of Public Health; the Department of
7 Human Services; and the Department of Financial and
8 Professional Regulation.

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

23 The Illinois Department shall establish policies,
24 procedures, standards and criteria by rule for the
25 acquisition, repair and replacement of orthotic and prosthetic
26 devices and durable medical equipment. Such rules shall

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

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

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

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

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

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

15 The Illinois Department shall report annually to the
16 General Assembly, no later than the second Friday in April of
17 1979 and each year thereafter, in regard to:

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

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

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

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

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

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

On or after July 1, 2015, opioid antagonists prescribed for the treatment of an opioid overdose, including the medication product, administration devices, and any pharmacy fees related to the dispensing and administration of the opioid antagonist, shall be covered under the medical

assistance program for persons who are otherwise eligible for medical assistance under this Article. As used in this Section, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

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

A federally qualified health center, as defined in Section 1905(l)(2)(B) of the federal Social Security Act, shall be reimbursed by the Department in accordance with the federally qualified health center's encounter rate for services provided to medical assistance recipients that are performed by a dental hygienist, as defined under the Illinois Dental Practice Act, working under the general supervision of a

dentist and employed by a federally qualified health center.
(Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; revised 9-18-19.)

Article 105.

Section 105-5. The Illinois Public Aid Code is amended by changing Section 5-30.1 as follows:

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

"Managed care organization" or "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

"Emergency services" include:

(1) emergency services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(2) emergency medical screening examinations, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(3) post-stabilization medical services, as defined by

1 Section 10 of the Managed Care Reform and Patient Rights
2 Act; and
3 (4) emergency medical conditions, as defined by
4 Section 10 of the Managed Care Reform and Patient Rights
5 Act.
6 (b) As provided by Section 5-16.12, managed care
7 organizations are subject to the provisions of the Managed
8 Care Reform and Patient Rights Act.
9 (c) An MCO shall pay any provider of emergency services
10 that does not have in effect a contract with the contracted
11 Medicaid MCO. The default rate of reimbursement shall be the
12 rate paid under Illinois Medicaid fee-for-service program
13 methodology, including all policy adjusters, including but not
14 limited to Medicaid High Volume Adjustments, Medicaid
15 Percentage Adjustments, Outpatient High Volume Adjustments,
16 and all outlier add-on adjustments to the extent such
17 adjustments are incorporated in the development of the
18 applicable MCO capitated rates.
19 (d) An MCO shall pay for all post-stabilization services
20 as a covered service in any of the following situations:
21 (1) the MCO authorized such services;
22 (2) such services were administered to maintain the
23 enrollee's stabilized condition within one hour after a
24 request to the MCO for authorization of further
25 post-stabilization services;
26 (3) the MCO did not respond to a request to authorize

such services within one hour;

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

(e) The following requirements apply to MCOs in determining payment for all emergency services:

(1) MCOs shall not impose any requirements for prior approval of emergency services.

(2) The MCO shall cover emergency services provided to enrollees who are temporarily away from their residence and outside the contracting area to the extent that the

enrollees would be entitled to the emergency services if they still were within the contracting area.

(3) The MCO shall have no obligation to cover medical services provided on an emergency basis that are not covered services under the contract.

(4) The MCO shall not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's screening and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the provider actually treating the enrollee, of whether an enrollee is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover emergency services for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider.

(6) The MCO's financial responsibility for post-stabilization care services it has not pre-approved ends when:

(A) a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(B) a plan physician assumes responsibility for the enrollee's care through transfer;

(C) a contracting entity representative and the treating physician reach an agreement concerning the

1 enrollee's care; or
2 (D) the enrollee is discharged.
3 (f) Network adequacy and transparency.
4 (1) The Department shall:
5 (A) ensure that an adequate provider network is in
6 place, taking into consideration health professional
7 shortage areas and medically underserved areas;
8 (B) publicly release an explanation of its process
9 for analyzing network adequacy;
10 (C) periodically ensure that an MCO continues to
11 have an adequate network in place;
12 (D) require MCOs, including Medicaid Managed Care
13 Entities as defined in Section 5-30.2, to meet
14 provider directory requirements under Section 5-30.3;
15 and
16 (E) require MCOs to ensure that any
17 Medicaid-certified provider under contract with an MCO
18 and previously submitted on a roster on the date of
19 service is paid for any medically necessary,
20 Medicaid-covered, and authorized service rendered to
21 any of the MCO's enrollees, regardless of inclusion on
22 the MCO's published and publicly available directory
23 of available providers.
24 (2) Each MCO shall confirm its receipt of information
25 submitted specific to physician or dentist additions or
26 physician or dentist deletions from the MCO's provider

1 network within 3 days after receiving all required
2 information from contracted physicians or dentists, and
3 electronic physician and dental directories must be
4 updated consistent with current rules as published by the
5 Centers for Medicare and Medicaid Services or its
6 successor agency.
7 (g) Timely payment of claims.
8 (1) The MCO shall pay a claim within 30 days of
9 receiving a claim that contains all the essential
10 information needed to adjudicate the claim.
11 (2) The MCO shall notify the billing party of its
12 inability to adjudicate a claim within 30 days of
13 receiving that claim.
14 (3) The MCO shall pay a penalty that is at least equal
15 to the timely payment interest penalty imposed under
16 Section 368a of the Illinois Insurance Code for any claims
17 not timely paid.
18 (A) When an MCO is required to pay a timely payment
19 interest penalty to a provider, the MCO must calculate
20 and pay the timely payment interest penalty that is
21 due to the provider within 30 days after the payment of
22 the claim. In no event shall a provider be required to
23 request or apply for payment of any owed timely
24 payment interest penalties.
25 (B) Such payments shall be reported separately
26 from the claim payment for services rendered to the

MCO's enrollee and clearly identified as interest payments.

(4)(A) The Department shall require MCOs to expedite payments to providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), on a schedule at least as frequently as the providers are paid under the Department's fee-for-service expedited provider schedule.

(B) Compliance with the expedited provider requirement may be satisfied by an MCO through the use of a Periodic Interim Payment (PIP) program that has been mutually agreed to and documented between the MCO and the provider, if the PIP program ensures that any expedited provider receives regular and periodic payments based on prior period payment experience from that MCO. Total payments under the PIP program may be reconciled against future PIP payments on a schedule mutually agreed to between the MCO and the provider.

(C) The Department shall share at least monthly its expedited provider list and the frequency with which it pays providers on the expedited list.

(g-5) Recognizing that the rapid transformation of the Illinois Medicaid program may have unintended operational challenges for both payers and providers:

(1) in no instance shall a medically necessary covered service rendered in good faith, based upon eligibility

1 information documented by the provider, be denied coverage
2 or diminished in payment amount if the eligibility or
3 coverage information available at the time the service was
4 rendered is later found to be inaccurate in the assignment
5 of coverage responsibility between MCOs or the
6 fee-for-service system, except for instances when an
7 individual is deemed to have not been eligible for
8 coverage under the Illinois Medicaid program; and
9 (2) the Department shall, by December 31, 2016, adopt
10 rules establishing policies that shall be included in the
11 Medicaid managed care policy and procedures manual
12 addressing payment resolutions in situations in which a
13 provider renders services based upon information obtained
14 after verifying a patient's eligibility and coverage plan
15 through either the Department's current enrollment system
16 or a system operated by the coverage plan identified by
17 the patient presenting for services:
18 (A) such medically necessary covered services
19 shall be considered rendered in good faith;
20 (B) such policies and procedures shall be
21 developed in consultation with industry
22 representatives of the Medicaid managed care health
23 plans and representatives of provider associations
24 representing the majority of providers within the
25 identified provider industry; and
26 (C) such rules shall be published for a review and

comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

The rules shall be applicable for both MCO coverage and fee-for-service coverage.

If the fee-for-service system is ultimately determined to have been responsible for coverage on the date of service, the Department shall provide for an extended period for claims submission outside the standard timely filing requirements.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

(2) The Department shall ensure that the metrics report is accessible to providers online by January 1, 2017.

(3) The metrics shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60,

90, and over 90 days, and the dollar amounts associated with those claims. ~~The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.~~

(g-8) Dispute resolution process. The Department shall maintain a provider complaint portal through which a provider can submit to the Department unresolved disputes with an MCO. An unresolved dispute means an MCO's decision that denies in whole or in part a claim for reimbursement to a provider for health care services rendered by the provider to an enrollee of the MCO with which the provider disagrees. Disputes shall not be submitted to the portal until the provider has availed itself of the MCO's internal dispute resolution process. Disputes that are submitted to the MCO internal dispute resolution process may be submitted to the Department of Healthcare and Family Services' complaint portal no sooner than 30 days after submitting to the MCO's internal process and not later than 30 days after the unsatisfactory resolution of the internal MCO process or 60 days after submitting the dispute to the MCO internal process. Multiple claim disputes involving the same MCO may be submitted in one complaint, regardless of whether the claims are for different enrollees, when the specific reason for non-payment of the claims involves a common question of fact or policy. Within 10 business days of receipt of a complaint, the Department shall present such disputes to the appropriate MCO, which shall then

have 30 days to issue its written proposal to resolve the dispute. The Department may grant one 30-day extension of this time frame to one of the parties to resolve the dispute. If the dispute remains unresolved at the end of this time frame or the provider is not satisfied with the MCO's written proposal to resolve the dispute, the provider may, within 30 days, request the Department to review the dispute and make a final determination. Within 30 days of the request for Department review of the dispute, both the provider and the MCO shall present all relevant information to the Department for resolution and make individuals with knowledge of the issues available to the Department for further inquiry if needed. Within 30 days of receiving the relevant information on the dispute, or the lapse of the period for submitting such information, the Department shall issue a written decision on the dispute based on contractual terms between the provider and the MCO, contractual terms between the MCO and the Department of Healthcare and Family Services and applicable Medicaid policy. The decision of the Department shall be final. By January 1, 2020, the Department shall establish by rule further details of this dispute resolution process. Disputes between MCOs and providers presented to the Department for resolution are not contested cases, as defined in Section 1-30 of the Illinois Administrative Procedure Act, conferring any right to an administrative hearing.

(g-9)(1) The Department shall publish annually on its

1 website a report on the calculation of each managed care
2 organization's medical loss ratio showing the following:
3 (A) Premium revenue, with appropriate adjustments.
4 (B) Benefit expense, setting forth the aggregate
5 amount spent for the following:
6 (i) Direct paid claims.
7 (ii) Subcapitation payments.
8 (iii) Other claim payments.
9 (iv) Direct reserves.
10 (v) Gross recoveries.
11 (vi) Expenses for activities that improve health
12 care quality as allowed by the Department.
13 (2) The medical loss ratio shall be calculated consistent
14 with federal law and regulation following a claims runout
15 period determined by the Department.
16 (g-10)(1) "Liability effective date" means the date on
17 which an MCO becomes responsible for payment for medically
18 necessary and covered services rendered by a provider to one
19 of its enrollees in accordance with the contract terms between
20 the MCO and the provider. The liability effective date shall
21 be the later of:
22 (A) The execution date of a network participation
23 contract agreement.
24 (B) The date the provider or its representative
25 submits to the MCO the complete and accurate standardized
26 roster form for the provider in the format approved by the

1 Department.
2 (C) The provider effective date contained within the
3 Department's provider enrollment subsystem within the
4 Illinois Medicaid Program Advanced Cloud Technology
5 (IMPACT) System.
6 (2) The standardized roster form may be submitted to the
7 MCO at the same time that the provider submits an enrollment
8 application to the Department through IMPACT.
9 (3) By October 1, 2019, the Department shall require all
10 MCOs to update their provider directory with information for
11 new practitioners of existing contracted providers within 30
12 days of receipt of a complete and accurate standardized roster
13 template in the format approved by the Department provided
14 that the provider is effective in the Department's provider
15 enrollment subsystem within the IMPACT system. Such provider
16 directory shall be readily accessible for purposes of
17 selecting an approved health care provider and comply with all
18 other federal and State requirements.
19 (g-11) The Department shall work with relevant
20 stakeholders on the development of operational guidelines to
21 enhance and improve operational performance of Illinois'
22 Medicaid managed care program, including, but not limited to,
23 improving provider billing practices, reducing claim
24 rejections and inappropriate payment denials, and
25 standardizing processes, procedures, definitions, and response
26 timelines, with the goal of reducing provider and MCO

administrative burdens and conflict. The Department shall include a report on the progress of these program improvements and other topics in its Fiscal Year 2020 annual report to the General Assembly.

(g-12) Notwithstanding any other provision of law, if the Department or an MCO requires submission of a claim for payment in a non-electronic format, a provider shall always be afforded a period of no less than 90 business days, as a correction period, following any notification of rejection by either the Department or the MCO to correct errors or omissions in the original submission.

Under no circumstances, either by an MCO or under the State's fee-for-service system, shall a provider be denied payment for failure to comply with any timely submission requirements under this Code or under any existing contract, unless the non-electronic format claim submission occurs after the initial 180 days following the latest date of service on the claim, or after the 90 business days correction period following notification to the provider of rejection or denial of payment.

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care

entities and MCOs to participate in such newly designated counties.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(j) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form that grants to the health care provider permission to release the recipient's health care information to the recipient's insurance carrier.

(k) The Department of Healthcare and Family Services, managed care organizations, a statewide organization representing hospitals, and a statewide organization representing safety-net hospitals shall explore ways to support billing departments in safety-net hospitals.

(l) The requirements of this Section added by this amendatory Act of the 102nd General Assembly shall apply to services provided on or after the first day of the month that begins 60 days after the effective date of this amendatory Act of the 102nd General Assembly.

1 (Source: P.A. 101-209, eff. 8-5-19; 102-4, eff. 4-27-21.)

2 Article 999.

3 Section 999-99. Effective date. This Act takes effect upon
4 becoming law.".