



Rep. Patricia R. Bellock

**Filed: 4/6/2016**

09900HB5641ham002

LRB099 20172 KTG 46538 a

1 AMENDMENT TO HOUSE BILL 5641

2 AMENDMENT NO. \_\_\_\_\_. Amend House Bill 5641 by replacing  
3 everything after the enacting clause with the following:

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

6 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

7 (Text of Section before amendment by P.A. 99-407)

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 home,

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

1 (15) medical treatment of sexual assault survivors, as defined  
2 in Section 1a of the Sexual Assault Survivors Emergency  
3 Treatment Act, for injuries sustained as a result of the sexual  
4 assault, including examinations and laboratory tests to  
5 discover evidence which may be used in criminal proceedings  
6 arising from the sexual assault; (16) the diagnosis and  
7 treatment of sickle cell anemia; and (17) any other medical  
8 care, and any other type of remedial care recognized under the  
9 laws of this State, but not including abortions, or induced  
10 miscarriages or premature births, unless, in the opinion of a  
11 physician, such procedures are necessary for the preservation  
12 of the life of the woman seeking such treatment, or except an  
13 induced premature birth intended to produce a live viable child  
14 and such procedure is necessary for the health of the mother or  
15 her unborn child. The Illinois Department, by rule, shall  
16 prohibit any physician from providing medical assistance to  
17 anyone eligible therefor under this Code where such physician  
18 has been found guilty of performing an abortion procedure in a  
19 wilful and wanton manner upon a woman who was not pregnant at  
20 the time such abortion procedure was performed. The term "any  
21 other type of remedial care" shall include nursing care and  
22 nursing home service for persons who rely on treatment by  
23 spiritual means alone through prayer for healing.

24 Notwithstanding any other provision of this Section, a  
25 comprehensive tobacco use cessation program that includes  
26 purchasing prescription drugs or prescription medical devices

1 approved by the Food and Drug Administration shall be covered  
2 under the medical assistance program under this Article for  
3 persons who are otherwise eligible for assistance under this  
4 Article.

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

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

1 Department or the MCE in which the individual is enrolled for  
2 payment and shall be reimbursed at the Department's or the  
3 MCE's established rates or rate methodologies for eyeglasses.

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

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

12 (2) eyeglasses prescribed by a physician skilled in the  
13 diseases of the eye, or by an optometrist, whichever the  
14 person may select.

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

1 this provision.

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

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

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

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

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

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

26 (D) A comprehensive ultrasound screening of an entire

1 breast or breasts if a mammogram demonstrates  
2 heterogeneous or dense breast tissue, when medically  
3 necessary as determined by a physician licensed to practice  
4 medicine in all of its branches.

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

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. For purposes of this Section, "low-dose mammography"  
12 means the x-ray examination of the breast using equipment  
13 dedicated specifically for mammography, including the x-ray  
14 tube, filter, compression device, and image receptor, with an  
15 average radiation exposure delivery of less than one rad per  
16 breast for 2 views of an average size breast. The term also  
17 includes digital mammography.

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

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

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

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

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

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

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



1 months, of the importance and benefit of screening mammography.  
2 The Department shall work with experts in breast cancer  
3 outreach and patient navigation to optimize these reminders and  
4 shall establish a methodology for evaluating their  
5 effectiveness and modifying the methodology based on the  
6 evaluation.

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

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

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

9           Any medical or health care provider shall immediately  
10 recommend, to any pregnant woman who is being provided prenatal  
11 services and is suspected of drug abuse or is addicted as  
12 defined in the Alcoholism and Other Drug Abuse and Dependency  
13 Act, referral to a local substance abuse treatment provider  
14 licensed by the Department of Human Services or to a licensed  
15 hospital which provides substance abuse treatment services.  
16 The Department of Healthcare and Family Services shall assure  
17 coverage for the cost of treatment of the drug abuse or  
18 addiction for pregnant recipients in accordance with the  
19 Illinois Medicaid Program in conjunction with the Department of  
20 Human Services.

21           All medical providers providing medical assistance to  
22 pregnant women under this Code shall receive information from  
23 the Department on the availability of services under the Drug  
24 Free Families with a Future or any comparable program providing  
25 case management services for addicted women, including  
26 information on appropriate referrals for other social services

1 that may be needed by addicted women in addition to treatment  
2 for addiction.

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

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

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

23 The Illinois Department may develop and contract with  
24 Partnerships of medical providers to arrange medical services  
25 for persons eligible under Section 5-2 of this Code.  
26 Implementation of this Section may be by demonstration projects

1 in certain geographic areas. The Partnership shall be  
2 represented by a sponsor organization. The Department, by rule,  
3 shall develop qualifications for sponsors of Partnerships.  
4 Nothing in this Section shall be construed to require that the  
5 sponsor organization be a medical organization.

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

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

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

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

1 medical assistance program.

2 Medical providers shall be required to meet certain  
3 qualifications to participate in Partnerships to ensure the  
4 delivery of high quality medical services. These  
5 qualifications shall be determined by rule of the Illinois  
6 Department and may be higher than qualifications for  
7 participation in the medical assistance program. Partnership  
8 sponsors may prescribe reasonable additional qualifications  
9 for participation by medical providers, only with the prior  
10 written approval of the Illinois Department.

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

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

23 The Illinois Department shall require health care  
24 providers to maintain records that document the medical care  
25 and services provided to recipients of Medical Assistance under  
26 this Article. Such records must be retained for a period of not

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

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

11 The rules and regulations of the Illinois Department shall  
12 require that a written statement including the required opinion  
13 of a physician shall accompany any claim for reimbursement for  
14 abortions, or induced miscarriages or premature births. This  
15 statement shall indicate what procedures were used in providing  
16 such medical services.

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

1 home claims.

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

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

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

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

23           (2) In the case of errors attributable to the Illinois  
24 Department or any of its claims processing intermediaries  
25 which result in an inability to receive, process, or  
26 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 5 days of  
16          receipt by the facility of required prescreening information,  
17          data for new admissions shall be entered into the Medical  
18          Electronic Data Interchange (MEDI) or the Recipient  
19          Eligibility Verification (REV) System or successor system, and  
20          within 15 days of receipt by the facility of required  
21          prescreening information, admission documents shall be  
22          submitted through MEDI or REV or shall be submitted directly to  
23          the Department of Human Services using required admission  
24          forms. Effective September 1, 2014, admission documents,  
25          including all prescreening information, must be submitted  
26          through MEDI or REV. Confirmation numbers assigned to an

1 accepted transaction shall be retained by a facility to verify  
2 timely submittal. Once an admission transaction has been  
3 completed, all resubmitted claims following prior rejection  
4 are subject to receipt no later than 180 days after the  
5 admission transaction has been completed.

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

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

24 The Illinois Department shall enter into agreements with  
25 State agencies and departments, and is authorized to enter into  
26 agreements with federal agencies and departments, under which

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

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

1 take any action or acquire any products or services.

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

17 The Department shall require by rule all providers of  
18 durable medical equipment to be accredited by an accreditation  
19 organization approved by the federal Centers for Medicare and  
20 Medicaid Services and recognized by the Department in order to  
21 bill the Department for providing durable medical equipment to  
22 recipients. No later than 90 days after the effective date of  
23 this amendatory Act of the 99th General Assembly, the  
24 Department shall file proposed rules in accordance with the  
25 Illinois Administrative Procedure Act to implement this  
26 requirement. No later than 15 months after the effective date

1 of the rule adopted pursuant to this paragraph, all providers  
2 must meet the accreditation requirement. The Department may  
3 contract with a third-party vendor to audit eligible durable  
4 medical equipment suppliers.

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 State  
12 where they are not currently available or are undeveloped; and  
13 (iii) notwithstanding any other provision of law, subject to  
14 federal approval, on and after July 1, 2012, an increase in the  
15 determination of need (DON) scores from 29 to 37 for applicants  
16 for institutional and home and community-based long term care;  
17 if and only if federal approval is not granted, the Department  
18 may, in conjunction with other affected agencies, implement  
19 utilization controls or changes in benefit packages to  
20 effectuate a similar savings amount for this population; and  
21 (iv) no later than July 1, 2013, minimum level of care  
22 eligibility criteria for institutional and home and  
23 community-based long term care; and (v) no later than October  
24 1, 2013, establish procedures to permit long term care  
25 providers access to eligibility scores for individuals with an  
26 admission date who are seeking or receiving services from the

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

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

16 The Illinois Department shall report annually to the  
17 General Assembly, no later than the second Friday in April of  
18 1979 and each year thereafter, in regard to:

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

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

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

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



1           The period covered by each report shall be the 3 years  
2 ending on the June 30 prior to the report. The report shall  
3 include suggested legislation for consideration by the General  
4 Assembly. The filing of one copy of the report with the  
5 Speaker, one copy with the Minority Leader and one copy with  
6 the Clerk of the House of Representatives, one copy with the  
7 President, one copy with the Minority Leader and one copy with  
8 the Secretary of the Senate, one copy with the Legislative  
9 Research Unit, and such additional copies with the State  
10 Government Report Distribution Center for the General Assembly  
11 as is required under paragraph (t) of Section 7 of the State  
12 Library Act shall be deemed sufficient to comply with this  
13 Section.

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 of  
23 reimbursement for services or other payments in accordance with  
24 Section 5-5e.

25           Because kidney transplantation can be an appropriate, cost  
26 effective alternative to renal dialysis when medically

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

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

26 On or after July 1, 2015, opioid antagonists prescribed for

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

12 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;  
13 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.  
14 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,  
15 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;  
16 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-433, eff.  
17 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

18 (Text of Section after amendment by P.A. 99-407)

19 Sec. 5-5. Medical services. The Illinois Department, by  
20 rule, shall determine the quantity and quality of and the rate  
21 of reimbursement for the medical assistance for which payment  
22 will be authorized, and the medical services to be provided,  
23 which may include all or part of the following: (1) inpatient  
24 hospital services; (2) outpatient hospital services; (3) other  
25 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 home,  
3 or elsewhere; (6) medical care, or any other type of remedial  
4 care furnished by licensed practitioners; (7) home health care  
5 services; (8) private duty nursing service; (9) clinic  
6 services; (10) dental services, including prevention and  
7 treatment of periodontal disease and dental caries disease for  
8 pregnant women, provided by an individual licensed to practice  
9 dentistry or dental surgery; for purposes of this item (10),  
10 "dental services" means diagnostic, preventive, or corrective  
11 procedures provided by or under the supervision of a dentist in  
12 the practice of his or her profession; (11) physical therapy  
13 and related services; (12) prescribed drugs, dentures, and  
14 prosthetic devices; and eyeglasses prescribed by a physician  
15 skilled in the diseases of the eye, or by an optometrist,  
16 whichever the person may select; (13) other diagnostic,  
17 screening, preventive, and rehabilitative services, including  
18 to ensure that the individual's need for intervention or  
19 treatment of mental disorders or substance use disorders or  
20 co-occurring mental health and substance use disorders is  
21 determined using a uniform screening, assessment, and  
22 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

1 instrument, tool, or process that all must utilize; (14)  
2 transportation and such other expenses as may be necessary;  
3 (15) medical treatment of sexual assault survivors, as defined  
4 in Section 1a of the Sexual Assault Survivors Emergency  
5 Treatment Act, for injuries sustained as a result of the sexual  
6 assault, including examinations and laboratory tests to  
7 discover evidence which may be used in criminal proceedings  
8 arising from the sexual assault; (16) the diagnosis and  
9 treatment of sickle cell anemia; and (17) any other medical  
10 care, and any other type of remedial care recognized under the  
11 laws of this State, but not including abortions, or induced  
12 miscarriages or premature births, unless, in the opinion of a  
13 physician, such procedures are necessary for the preservation  
14 of the life of the woman seeking such treatment, or except an  
15 induced premature birth intended to produce a live viable child  
16 and such procedure is necessary for the health of the mother or  
17 her unborn child. The Illinois Department, by rule, shall  
18 prohibit any physician from providing medical assistance to  
19 anyone eligible therefor under this Code where such physician  
20 has been found guilty of performing an abortion procedure in a  
21 wilful and wanton manner upon a woman who was not pregnant at  
22 the time such abortion procedure was performed. The term "any  
23 other type of remedial care" shall include nursing care and  
24 nursing home service for persons who rely on treatment by  
25 spiritual means alone through prayer for healing.

26 Notwithstanding any other provision of this Section, a

1 comprehensive tobacco use cessation program that includes  
2 purchasing prescription drugs or prescription medical devices  
3 approved by the Food and Drug Administration shall be covered  
4 under the medical assistance program under this Article for  
5 persons who are otherwise eligible for assistance under this  
6 Article.

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

14 Upon receipt of federal approval of an amendment to the  
15 Illinois Title XIX State Plan for this purpose, the Department  
16 shall authorize the Chicago Public Schools (CPS) to procure a  
17 vendor or vendors to manufacture eyeglasses for individuals  
18 enrolled in a school within the CPS system. CPS shall ensure  
19 that its vendor or vendors are enrolled as providers in the  
20 medical assistance program and in any capitated Medicaid  
21 managed care entity (MCE) serving individuals enrolled in a  
22 school within the CPS system. Under any contract procured under  
23 this provision, the vendor or vendors must serve only  
24 individuals enrolled in a school within the CPS system. Claims  
25 for services provided by CPS's vendor or vendors to recipients  
26 of benefits in the medical assistance program under this Code,

1 the Children's Health Insurance Program, or the Covering ALL  
2 KIDS Health Insurance Program shall be submitted to the  
3 Department or the MCE in which the individual is enrolled for  
4 payment and shall be reimbursed at the Department's or the  
5 MCE's established rates or rate methodologies for eyeglasses.

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

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

14 (2) eyeglasses prescribed by a physician skilled in the  
15 diseases of the eye, or by an optometrist, whichever the  
16 person may select.

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

1 The Department shall establish a process for payment of claims  
2 for reimbursement for covered dental services rendered under  
3 this provision.

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

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

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

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

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

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



1 positive genetic testing, or other risk factors.

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

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

10 All screenings shall include a physical breast exam,  
11 instruction on self-examination and information regarding the  
12 frequency of self-examination and its value as a preventative  
13 tool. For purposes of this Section, "low-dose mammography"  
14 means the x-ray examination of the breast using equipment  
15 dedicated specifically for mammography, including the x-ray  
16 tube, filter, compression device, and image receptor, with an  
17 average radiation exposure delivery of less than one rad per  
18 breast for 2 views of an average size breast. The term also  
19 includes digital mammography and includes breast  
20 tomosynthesis. As used in this Section, the term "breast  
21 tomosynthesis" means a radiologic procedure that involves the  
22 acquisition of projection images over the stationary breast to  
23 produce cross-sectional digital three-dimensional images of  
24 the breast.

25 On and after January 1, 2016, the Department shall ensure  
26 that all networks of care for adult clients of the Department

1 include access to at least one breast imaging Center of Imaging  
2 Excellence as certified by the American College of Radiology.

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

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

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

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

24 Subject to federal approval, the Department shall  
25 establish a rate methodology for mammography at federally  
26 qualified health centers and other encounter-rate clinics.

1 These clinics or centers may also collaborate with other  
2 hospital-based mammography facilities. By January 1, 2016, the  
3 Department shall report to the General Assembly on the status  
4 of the provision set forth in this paragraph.

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

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

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

1 2016, the pilot program shall be expanded to include one site  
2 in western Illinois, one site in southern Illinois, one site in  
3 central Illinois, and 4 sites within metropolitan Chicago. An  
4 evaluation of the pilot program shall be carried out measuring  
5 health outcomes and cost of care for those served by the pilot  
6 program compared to similarly situated patients who are not  
7 served by the pilot program.

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

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

1 Human Services.

2 All medical providers providing medical assistance to  
3 pregnant women under this Code shall receive information from  
4 the Department on the availability of services under the Drug  
5 Free Families with a Future or any comparable program providing  
6 case management services for addicted women, including  
7 information on appropriate referrals for other social services  
8 that may be needed by addicted women in addition to treatment  
9 for addiction.

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

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

21 The Illinois Department shall establish such regulations  
22 governing the dispensing of health services under this Article  
23 as it shall deem appropriate. The Department should seek the  
24 advice of formal professional advisory committees appointed by  
25 the Director of the Illinois Department for the purpose of  
26 providing regular advice on policy and administrative matters,

1 information dissemination and educational activities for  
2 medical and health care providers, and consistency in  
3 procedures to the Illinois Department.

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

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

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

1 services.

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

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

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

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

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

4           The Illinois Department shall require health care  
5 providers to maintain records that document the medical care  
6 and services provided to recipients of Medical Assistance under  
7 this Article. Such records must be retained for a period of not  
8 less than 6 years from the date of service or as provided by  
9 applicable State law, whichever period is longer, except that  
10 if an audit is initiated within the required retention period  
11 then the records must be retained until the audit is completed  
12 and every exception is resolved. The Illinois Department shall  
13 require health care providers to make available, when  
14 authorized by the patient, in writing, the medical records in a  
15 timely fashion to other health care providers who are treating  
16 or serving persons eligible for Medical Assistance under this  
17 Article. All dispensers of medical services shall be required  
18 to maintain and retain business and professional records  
19 sufficient to fully and accurately document the nature, scope,  
20 details and receipt of the health care provided to persons  
21 eligible for medical assistance under this Code, in accordance  
22 with regulations promulgated by the Illinois Department. The  
23 rules and regulations shall require that proof of the receipt  
24 of prescription drugs, dentures, prosthetic devices and  
25 eyeglasses by eligible persons under this Section accompany  
26 each claim for reimbursement submitted by the dispenser of such



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

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

24 Notwithstanding any other law to the contrary, the Illinois  
25 Department shall, within 365 days after July 22, 2013 (the  
26 effective date of Public Act 98-104), establish procedures to

1 permit skilled care facilities licensed under the Nursing Home  
2 Care Act to submit monthly billing claims for reimbursement  
3 purposes. Following development of these procedures, the  
4 Department shall, by July 1, 2016, test the viability of the  
5 new system and implement any necessary operational or  
6 structural changes to its information technology platforms in  
7 order to allow for the direct acceptance and payment of nursing  
8 home claims.

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

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

1 health care services in this State under this Article.

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

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

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

22 Prior to enrollment and during the conditional enrollment  
23 period in the medical assistance program, all vendors shall be  
24 subject to enhanced oversight, screening, and review based on  
25 the risk of fraud, waste, and abuse that is posed by the  
26 category of risk of the vendor. The Illinois Department shall

1 establish the procedures for oversight, screening, and review,  
2 which may include, but need not be limited to: criminal and  
3 financial background checks; fingerprinting; license,  
4 certification, and authorization verifications; unscheduled or  
5 unannounced site visits; database checks; prepayment audit  
6 reviews; audits; payment caps; payment suspensions; and other  
7 screening as required by federal or State law.

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

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

25 (1) In the case of a provider whose enrollment is in  
26 process by the Illinois Department, the 180-day period

1 shall not begin until the date on the written notice from  
2 the Illinois Department that the provider enrollment is  
3 complete.

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

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

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

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

22 In the case of long term care facilities, within 5 days of  
23 receipt by the facility of required prescreening information,  
24 data for new admissions shall be entered into the Medical  
25 Electronic Data Interchange (MEDI) or the Recipient  
26 Eligibility Verification (REV) System or successor system, and

1 within 15 days of receipt by the facility of required  
2 prescreening information, admission documents shall be  
3 submitted through MEDI or REV or shall be submitted directly to  
4 the Department of Human Services using required admission  
5 forms. Effective September 1, 2014, admission documents,  
6 including all prescreening information, must be submitted  
7 through MEDI or REV. Confirmation numbers assigned to an  
8 accepted transaction shall be retained by a facility to verify  
9 timely submittal. Once an admission transaction has been  
10 completed, all resubmitted claims following prior rejection  
11 are subject to receipt no later than 180 days after the  
12 admission transaction has been completed.

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

17 To the extent consistent with applicable information and  
18 privacy, security, and disclosure laws, State and federal  
19 agencies and departments shall provide the Illinois Department  
20 access to confidential and other information and data necessary  
21 to perform eligibility and payment verifications and other  
22 Illinois Department functions. This includes, but is not  
23 limited to: information pertaining to licensure;  
24 certification; earnings; immigration status; citizenship; wage  
25 reporting; unearned and earned income; pension income;  
26 employment; supplemental security income; social security

1 numbers; National Provider Identifier (NPI) numbers; the  
2 National Practitioner Data Bank (NPDB); program and agency  
3 exclusions; taxpayer identification numbers; tax delinquency;  
4 corporate information; and death records.

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

21 Beginning in fiscal year 2013, the Illinois Department  
22 shall set forth a request for information to identify the  
23 benefits of a pre-payment, post-adjudication, and post-edit  
24 claims system with the goals of streamlining claims processing  
25 and provider reimbursement, reducing the number of pending or  
26 rejected claims, and helping to ensure a more transparent

1 adjudication process through the utilization of: (i) provider  
2 data verification and provider screening technology; and (ii)  
3 clinical code editing; and (iii) pre-pay, pre- or  
4 post-adjudicated predictive modeling with an integrated case  
5 management system with link analysis. Such a request for  
6 information shall not be considered as a request for proposal  
7 or as an obligation on the part of the Illinois Department to  
8 take any action or acquire any products or services.

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

24 The Department shall require by rule all providers of  
25 durable medical equipment to be accredited by an accreditation  
26 organization approved by the federal Centers for Medicare and



1 Medicaid Services and recognized by the Department in order to  
2 bill the Department for providing durable medical equipment to  
3 recipients. No later than 90 days after the effective date of  
4 this amendatory Act of the 99th General Assembly, the  
5 Department shall file proposed rules in accordance with the  
6 Illinois Administrative Procedure Act to implement this  
7 requirement. No later than 15 months after the effective date  
8 of the rule adopted pursuant to this paragraph, all providers  
9 must meet the accreditation requirement. The Department may  
10 contract with a third-party vendor to audit eligible durable  
11 medical equipment suppliers.

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

1 effectuate a similar savings amount for this population; and  
2 (iv) no later than July 1, 2013, minimum level of care  
3 eligibility criteria for institutional and home and  
4 community-based long term care; and (v) no later than October  
5 1, 2013, establish procedures to permit long term care  
6 providers access to eligibility scores for individuals with an  
7 admission date who are seeking or receiving services from the  
8 long term care provider. In order to select the minimum level  
9 of care eligibility criteria, the Governor shall establish a  
10 workgroup that includes affected agency representatives and  
11 stakeholders representing the institutional and home and  
12 community-based long term care interests. This Section shall  
13 not restrict the Department from implementing lower level of  
14 care eligibility criteria for community-based services in  
15 circumstances where federal approval has been granted.

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

23 The Illinois Department shall report annually to the  
24 General Assembly, no later than the second Friday in April of  
25 1979 and each year thereafter, in regard to:

26 (a) actual statistics and trends in utilization of

1 medical services by public aid recipients;

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

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

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

8 The period covered by each report shall be the 3 years  
9 ending on the June 30 prior to the report. The report shall  
10 include suggested legislation for consideration by the General  
11 Assembly. The filing of one copy of the report with the  
12 Speaker, one copy with the Minority Leader and one copy with  
13 the Clerk of the House of Representatives, one copy with the  
14 President, one copy with the Minority Leader and one copy with  
15 the Secretary of the Senate, one copy with the Legislative  
16 Research Unit, and such additional copies with the State  
17 Government Report Distribution Center for the General Assembly  
18 as is required under paragraph (t) of Section 7 of the State  
19 Library Act shall be deemed sufficient to comply with this  
20 Section.

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

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

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

22           Notwithstanding any other provision of this Code to the  
23 contrary, on or after July 1, 2015, all FDA approved forms of  
24 medication assisted treatment prescribed for the treatment of  
25 alcohol dependence or treatment of opioid dependence shall be  
26 covered under both fee for service and managed care medical

1 assistance programs for persons who are otherwise eligible for  
2 medical assistance under this Article and shall not be subject  
3 to any (1) utilization control, other than those established  
4 under the American Society of Addiction Medicine patient  
5 placement criteria, (2) prior authorization mandate, or (3)  
6 lifetime restriction limit mandate.

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

19 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;  
20 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.  
21 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,  
22 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;  
23 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section  
24 99 of P.A. 99-407 for its effective date); 99-433, eff.  
25 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

1           Section 95. No acceleration or delay. Where this Act makes  
2 changes in a statute that is represented in this Act by text  
3 that is not yet or no longer in effect (for example, a Section  
4 represented by multiple versions), the use of that text does  
5 not accelerate or delay the taking effect of (i) the changes  
6 made by this Act or (ii) provisions derived from any other  
7 Public Act.".