

101ST GENERAL ASSEMBLY
State of Illinois
2019 and 2020
HB0004

Introduced , by Rep. Mary E. Flowers

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

from Ch. 23, par. 5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that doula services shall be covered under the medical assistance program. Sets forth certain certification and training requirements a doula must satisfy to qualify for reimbursement under the medical assistance program.

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FISCAL NOTE ACT MAY
APPLY

A BILL FOR

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1 AN ACT concerning public aid.

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

4 Section 5. The Illinois Public Aid Code is amended by

5 changing Section 5-5 as follows:

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

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

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1 procedures provided by or under the supervision of a dentist in
2 the practice of his or her profession; (11) physical therapy
3 and related services; (12) prescribed drugs, dentures, and
4 prosthetic devices; and eyeglasses prescribed by a physician
5 skilled in the diseases of the eye, or by an optometrist,
6 whichever the person may select; (13) other diagnostic,
7 screening, preventive, and rehabilitative services, including
8 to ensure that the individual's need for intervention or
9 treatment of mental disorders or substance use disorders or
10 co-occurring mental health and substance use disorders is
11 determined using a uniform screening, assessment, and
12 evaluation process inclusive of criteria, for children and
13 adults; for purposes of this item (13), a uniform screening,
14 assessment, and evaluation process refers to a process that
15 includes an appropriate evaluation and, as warranted, a
16 referral; "uniform" does not mean the use of a singular

17 instrument, tool, or process that all must utilize; (14)
18 transportation and such other expenses as may be necessary;
19 (15) medical treatment of sexual assault survivors, as defined
20 in Section 1a of the Sexual Assault Survivors Emergency
21 Treatment Act, for injuries sustained as a result of the sexual
22 assault, including examinations and laboratory tests to
23 discover evidence which may be used in criminal proceedings
24 arising from the sexual assault; (16) the diagnosis and
25 treatment of sickle cell anemia; and (17) any other medical
26 care, and any other type of remedial care recognized under the

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

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

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

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

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

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

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

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

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

1 On and after July 1, 2018, the Department of Healthcare and
2 Family Services shall provide dental services to any adult who
3 is otherwise eligible for assistance under the medical
4 assistance program. As used in this paragraph, "dental

5 services" means diagnostic, preventative, restorative, or
6 corrective procedures, including procedures and services for
7 the prevention and treatment of periodontal disease and dental
8 caries disease, provided by an individual who is licensed to
9 practice dentistry or dental surgery or who is under the
10 supervision of a dentist in the practice of his or her
11 profession.

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

22 Notwithstanding any other provision of this Code and
23 subject to federal approval, the Department may adopt rules to
24 allow a dentist who is volunteering his or her service at no
25 cost to render dental services through an enrolled
26 not-for-profit health clinic without the dentist personally

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

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

12 The Department of Healthcare and Family Services must
13 provide coverage and reimbursement for amino acid-based
14

15 elemental formulas, regardless of delivery method, for the
16 diagnosis and treatment of (i) eosinophilic disorders and (ii)
17 short bowel syndrome when the prescribing physician has issued
18 a written order stating that the amino acid-based elemental
19 formula is medically necessary.

20 The Illinois Department shall authorize the provision of,
21 and shall authorize payment for, screening by low-dose
22 mammography for the presence of occult breast cancer for women
23 35 years of age or older who are eligible for medical
24 assistance under this Article, as follows:

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

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

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1 older.

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

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

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

15 All screenings shall include a physical breast exam,
16 instruction on self-examination and information regarding the
17 frequency of self-examination and its value as a preventative
18 tool. For purposes of this Section, "low-dose mammography"
19 means the x-ray examination of the breast using equipment
20 dedicated specifically for mammography, including the x-ray
21 tube, filter, compression device, and image receptor, with an
22 average radiation exposure delivery of less than one rad per

23 breast for 2 views of an average size breast. The term also
24 includes digital mammography and includes breast
25 tomosynthesis. As used in this Section, the term "breast
26 tomosynthesis" means a radiologic procedure that involves the

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1 acquisition of projection images over the stationary breast to
2 produce cross-sectional digital three-dimensional images of
3 the breast. 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 the
6 Federal Register or publishes a comment in the Federal Register
7 or issues an opinion, guidance, or other action that would
8 require the State, pursuant to any provision of the Patient
9 Protection and Affordable Care Act (Public Law 111-148),
10 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
11 successor provision, to defray the cost of any coverage for
12 breast tomosynthesis outlined in this paragraph, then the
13 requirement that an insurer cover breast tomosynthesis is
14 inoperative other than any such coverage authorized under
15 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
16 the State shall not assume any obligation for the cost of
17 coverage for breast tomosynthesis set forth in this paragraph.

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.

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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 ~~free-standing~~
13 breast cancer treatment centers, breast cancer quality
14 organizations, and doctors, including breast surgeons,
15 reconstructive breast surgeons, oncologists, and primary care
16 providers to establish quality standards for breast cancer
17 treatment.

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

25 The Department shall establish a methodology to remind
26 women who are age-appropriate for screening mammography, but

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

8 The Department shall establish a performance goal for
9 primary care providers with respect to their female patients
10 over age 40 receiving an annual mammogram. This performance
11

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 program
18 in areas of the State with the highest incidence of mortality
19 related to breast cancer. At least one pilot program site shall
20 be in the metropolitan Chicago area and at least one site shall
21 be outside the metropolitan Chicago area. On or after July 1,
22 2016, the pilot program shall be expanded to include one site
23 in western Illinois, one site in southern Illinois, one site in
24 central Illinois, and 4 sites within metropolitan Chicago. An
25 evaluation of the pilot program shall be carried out measuring
26 health outcomes and cost of care for those served by the pilot
program compared to similarly situated patients who are not

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1 served by the pilot program.

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

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

conjunction with the Department of 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 any
24 program providing case management services for addicted women,
25 including information on appropriate referrals for other
26 social services that may be needed by addicted women in

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1 addition to treatment for addiction.

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

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

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

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

1 represented by a sponsor organization. The Department, by rule,
2 shall develop qualifications for sponsors of Partnerships.
3 Nothing in this Section shall be construed to require that the
4 sponsor organization be a medical 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 the
14 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 the
18 Partnership may receive an additional surcharge for such
19 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 provided
15 services may be accessed from therapeutically certified
16 optometrists to the full extent of the Illinois Optometric
17 Practice Act of 1987 without discriminating between service
18 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 under
25 this Article. Such records must be retained for a period of not
26 less than 6 years from the date of service or as provided by

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1 applicable State law, whichever period is longer, except that
2 if an audit is initiated within the required retention period
3 then the records must be retained until the audit is completed
4 and every exception is resolved. The Illinois Department shall
5 require health care providers to make available, when
6 authorized by the patient, in writing, the medical records in a
7 timely fashion to other health care providers who are treating
8 or serving persons eligible for Medical Assistance under this
9 Article. All dispensers of medical services shall be required
10 to maintain and retain business and professional records
11 sufficient to fully and accurately document the nature, scope,
12 details and receipt of the health care provided to persons
13 eligible for medical assistance under this Code, in accordance
14 with regulations promulgated by the Illinois Department. The
15 rules and regulations shall require that proof of the receipt
16 of prescription drugs, dentures, prosthetic devices and
17

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
is being made are actually being received by eligible

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

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

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

1 development of these procedures, the Department shall have an
2 additional 365 days to test the viability of the new system and
3 to ensure that any necessary operational or structural changes
4 to its information technology platforms are implemented.

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

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

22 Enrollment of a vendor shall be subject to a provisional
23 period and shall be conditional for one year. During the period
24 of conditional enrollment, the Department may terminate the
25 vendor's eligibility to participate in, or may disenroll the
26 vendor from, the medical assistance program without cause.

1 Unless otherwise specified, such termination of eligibility or
2 disenrollment is not subject to the Department's hearing
3 process. However, a disenrolled vendor may reapply without
4 penalty.

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

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

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

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1 hearing rights, if any, afforded to a vendor in each category
2 of risk of the vendor that is terminated or disenrolled during
3 the conditional enrollment period.

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

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

14 the Illinois Department that the provider enrollment is
15 complete.

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

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

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

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

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

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

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

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

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1 federal agencies and departments, including but not limited to:

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

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

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

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1 recipient's medical prognosis, the extent of the recipient's
2 needs, and the requirements and costs for maintaining such
3 equipment. Subject to prior approval, such rules shall enable a
4 recipient to temporarily acquire and use alternative or
5 substitute devices or equipment pending repairs or
6 replacements of any device or equipment previously authorized
7 for such recipient by the Department. Notwithstanding any
8 provision of Section 5-5f to the contrary, the Department may,
9 by rule, exempt certain replacement wheelchair parts from prior
10 approval and, for wheelchairs, wheelchair parts, wheelchair
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accessories, and related seating and positioning items,
12 determine the wholesale price by methods other than actual
13 acquisition costs.

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

22 In order to promote environmental responsibility, meet the
23 needs of recipients and enrollees, and achieve significant cost
24 savings, the Department, or a managed care organization under
25 contract with the Department, may provide recipients or managed
26 care enrollees who have a prescription or Certificate of

1 Medical Necessity access to refurbished durable medical
2 equipment under this Section (excluding prosthetic and
3 orthotic devices as defined in the Orthotics, Prosthetics, and
4 Pedorthics Practice Act and complex rehabilitation technology
5 products and associated services) through the State's
6 assistive technology program's reutilization program, using
7 staff with the Assistive Technology Professional (ATP)
8 Certification if the refurbished durable medical equipment:
9 (i) is available; (ii) is less expensive, including shipping
10 costs, than new durable medical equipment of the same type;
11 (iii) is able to withstand at least 3 years of use; (iv) is
12 cleaned, disinfected, sterilized, and safe in accordance with
13 federal Food and Drug Administration regulations and guidance
14 governing the reprocessing of medical devices in health care
15 settings; and (v) equally meets the needs of the recipient or
16 enrollee. The reutilization program shall confirm that the
17 recipient or enrollee is not already in receipt of same or
18 similar equipment from another service provider, and that the
19 refurbished durable medical equipment equally meets the needs
20

of the recipient or enrollee. Nothing in this paragraph shall
21 be construed to limit recipient or enrollee choice to obtain
22 new durable medical equipment or place any additional prior
23 authorization conditions on enrollees of managed care
24 organizations.

25 The Department shall execute, relative to the nursing home
26 prescreening project, written inter-agency agreements with the

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

1 care eligibility criteria for community-based services in
2 circumstances where federal approval has been granted.

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

10 The Illinois Department shall report annually to the
11 General Assembly, no later than the second Friday in April of
12 1979 and each year thereafter, in regard to:

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

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

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

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

21 The period covered by each report shall be the 3 years
22 ending on the June 30 prior to the report. The report shall
23 include suggested legislation for consideration by the General
24 Assembly. The filing of one copy of the report with the
25 Speaker, one copy with the Minority Leader and one copy with
26 the Clerk of the House of Representatives, one copy with the

1 President, one copy with the Minority Leader and one copy with
2 the Secretary of the Senate, one copy with the Legislative
3 Research Unit, and such additional copies with the State
4 Government Report Distribution Center for the General Assembly
5 as is required under paragraph (t) of Section 7 of the State
6 Library Act shall be deemed sufficient to comply with this
7 Section.

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

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

19 Because kidney transplantation can be an appropriate,
20 cost-effective ~~cost-effective~~ alternative to renal dialysis
21 when medically necessary and notwithstanding the provisions of
22 Section 1-11 of this Code, beginning October 1, 2014, the
23 Department shall cover kidney transplantation for noncitizens
24 with end-stage renal disease who are not eligible for
25 comprehensive medical benefits, who meet the residency
26 requirements of Section 5-3 of this Code, and who would

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1 otherwise meet the financial requirements of the appropriate
2 class of eligible persons under Section 5-2 of this Code. To
3 qualify for coverage of kidney transplantation, such person
4 must be receiving emergency renal dialysis services covered by
5 the Department. Providers under this Section shall be prior
6 approved and certified by the Department to perform kidney
7 transplantation and the services under this Section shall be
8 limited to services associated with kidney transplantation.

9 Notwithstanding any other provision of this Code to the
10 contrary, on or after July 1, 2015, all FDA approved forms of
11 medication assisted treatment prescribed for the treatment of
12 alcohol dependence or treatment of opioid dependence shall be
13 covered under both fee for service and managed care medical
14 assistance programs for persons who are otherwise eligible for
15 medical assistance under this Article and shall not be subject
16 to any (1) utilization control, other than those established
17

under the American Society of Addiction Medicine patient
18 placement criteria, (2) prior authorization mandate, or (3)
19 lifetime restriction limit mandate.

20 On or after July 1, 2015, opioid antagonists prescribed for
21 the treatment of an opioid overdose, including the medication
22 product, administration devices, and any pharmacy fees related
23 to the dispensing and administration of the opioid antagonist,
24 shall be covered under the medical assistance program for
25 persons who are otherwise eligible for medical assistance under
26 this Article. As used in this Section, "opioid antagonist"

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1 means a drug that binds to opioid receptors and blocks or
2 inhibits the effect of opioids acting on those receptors,
3 including, but not limited to, naloxone hydrochloride or any
4 other similarly acting drug approved by the U.S. Food and Drug
5 Administration.

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

18 A federally qualified health center, as defined in Section
19 1905(1)(2)(B) of the federal Social Security Act, shall be
20 reimbursed by the Department in accordance with the federally
21 qualified health center's encounter rate for services provided
22 to medical assistance recipients that are performed by a dental
23 hygienist, as defined under the Illinois Dental Practice Act,
24 working under the general supervision of a dentist and employed
25 by a federally qualified health center.
26

1 Illinois Department shall authorize licensed dietitian
2 nutritionists and certified diabetes educators to counsel
3 senior diabetes patients in the senior diabetes patients' homes
4 to remove the hurdle of transportation for senior diabetes
5 patients to receive treatment.

6 Notwithstanding any other provision of this Code, doula
7 services shall be covered under the medical assistance program
8 for persons who are otherwise eligible for medical assistance
9 under this Article. To be eligible for reimbursement under this
10 paragraph, the individual providing doula services must: (i) be
11 certified by an entity that is nationally recognized for
12 training and certifying doulas and that is approved by the
13 Department; (ii) have completed a cultural competency course;
14 (iii) have completed a course on Health Insurance Portability
15 and Accountability Act compliance; (iv) be certified to perform
16 cardiopulmonary resuscitation; and (v) be willing to submit to
17 a federal and State criminal history background check. As used
18 in this paragraph, "cultural competency course" means training
19 in cultural sensitivity, cultural respect, and cultural
20 humility that instructs a doula on how to acquire and use
21 knowledge of the health-related beliefs, attitudes, practices,
22 and communication patterns of clients and their families to
23 improve services, strengthen programs, increase community
24 participation, and close the gaps in health status among
25 diverse population groups.

26 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;

1 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
2 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;
3 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
4 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,

5 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
6 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff.
7 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18;
8 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; revised
9 10-9-18.)