1 AN ACT concerning regulation.

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

4 Section 5. The Illinois Insurance Code is amended by
5 changing Section 356g as follows:

6 (215 ILCS 5/356g) (from Ch. 73, par. 968g)
7 Sec. 356g. Mammograms; mastectomies.
8 (a) Every insurer shall provide in each group or individual
9 policy, contract, or certificate of insurance issued or renewed
10 for persons who are residents of this State, coverage for
11 screening by low-dose mammography for all women 35 years of age
12 or older for the presence of occult breast cancer within the
13 provisions of the policy, contract, or certificate. The
14 coverage shall be as follows:
15 (1) A baseline mammogram for women 35 to 39 years of
16 age.
17 (2) An annual mammogram for women 40 years of age or
18 older.
19 (3) A mammogram at the age and intervals considered
20 medically necessary by the woman's health care provider for
21 women under 40 years of age and having a family history of
22 breast cancer, prior personal history of breast cancer,
23 positive genetic testing, or other risk factors.

1 (4) A comprehensive ultrasound screening and MRI of an
2 entire breast or breasts if a mammogram demonstrates
3 heterogeneous or dense breast tissue, when medically
4 necessary as determined by a physician licensed to practice
5 medicine in all of its branches.
6 (5) A screening MRI when medically necessary, as
7 determined by a physician licensed to practice medicine in
8 all of its branches.
9 For purposes of this Section, "low-dose mammography" means
10 the x-ray examination of the breast using equipment dedicated
11 specifically for mammography, including the x-ray tube,
12 filter, compression device, and image receptor, with radiation
13 exposure delivery of less than 1 rad per breast for 2 views of
14 an average size breast. The term also includes digital
15 mammography and includes breast tomosynthesis. As used in this
16 Section, the term "breast tomosynthesis" means a radiologic
17 procedure that involves the acquisition of projection images
18 over the stationary breast to produce cross-sectional digital
19 three-dimensional images of the breast.
20 If, at any time, the Secretary of the United States
21 Department of Health and Human Services, or its successor
22 agency, promulgates rules or regulations to be published in the
23 Federal Register or publishes a comment in the Federal Register
24 or issues an opinion, guidance, or other action that would
25 require the State, pursuant to any provision of the Patient
26 Protection and Affordable Care Act (Public Law 111-148),

1 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
2 successor provision, to defray the cost of any coverage for
3 breast tomosynthesis outlined in this subsection, then the
4 requirement that an insurer cover breast tomosynthesis is
5 inoperative other than any such coverage authorized under
6 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
7 the State shall not assume any obligation for the cost of
8 coverage for breast tomosynthesis set forth in this subsection.
9 (a-5) Coverage as described by subsection (a) shall be
10 provided at no cost to the insured and shall not be applied to
11 an annual or lifetime maximum benefit.
12 (a-10) When health care services are available through
13 contracted providers and a person does not comply with plan
14 provisions specific to the use of contracted providers, the
15 requirements of subsection (a-5) are not applicable. When a
16 person does not comply with plan provisions specific to the use
17 of contracted providers, plan provisions specific to the use of
18 non-contracted providers must be applied without distinction
19 for coverage required by this Section and shall be at least as
20 favorable as for other radiological examinations covered by the
21 policy or contract.
22 (b) No policy of accident or health insurance that provides
23 for the surgical procedure known as a mastectomy shall be
24 issued, amended, delivered, or renewed in this State unless
25 that coverage also provides for prosthetic devices or
26 reconstructive surgery incident to the mastectomy. Coverage

1 for breast reconstruction in connection with a mastectomy shall
2 include:
3 (1) reconstruction of the breast upon which the
4 mastectomy has been performed;
5 (2) surgery and reconstruction of the other breast to
6 produce a symmetrical appearance; and
7 (3) prostheses and treatment for physical
8 complications at all stages of mastectomy, including
9 lymphedemas.
10 Care shall be determined in consultation with the attending
11 physician and the patient. The offered coverage for prosthetic
12 devices and reconstructive surgery shall be subject to the
13 deductible and coinsurance conditions applied to the
14 mastectomy, and all other terms and conditions applicable to
15 other benefits. When a mastectomy is performed and there is no
16 evidence of malignancy then the offered coverage may be limited
17 to the provision of prosthetic devices and reconstructive
18 surgery to within 2 years after the date of the mastectomy. As
19 used in this Section, "mastectomy" means the removal of all or
20 part of the breast for medically necessary reasons, as
21 determined by a licensed physician.
22 Written notice of the availability of coverage under this
23 Section shall be delivered to the insured upon enrollment and
24 annually thereafter. An insurer may not deny to an insured
25 eligibility, or continued eligibility, to enroll or to renew
26 coverage under the terms of the plan solely for the purpose of

1 avoiding the requirements of this Section. An insurer may not
2 penalize or reduce or limit the reimbursement of an attending
3 provider or provide incentives (monetary or otherwise) to an
4 attending provider to induce the provider to provide care to an
5 insured in a manner inconsistent with this Section.

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

12 (Source: P.A. 99-407 (see Section 20 of P.A. 99-588 for the
13 effective date of P.A. 99-407); 99-433, eff. 8-21-15; 99-588,
14 eff. 7-20-16; 99-642, eff. 7-28-16.)

15 Section 10. The Health Maintenance Organization Act is
16 amended by changing Section 4-6.1 as follows:

17 (215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)

18 Sec. 4-6.1. Mammograms; mastectomies.

19 (a) Every contract or evidence of coverage issued by a
20 Health Maintenance Organization for persons who are residents
21 of this State shall contain coverage for screening by low-dose
22 mammography for all women 35 years of age or older for the
23 presence of occult breast cancer. The coverage shall be as
24 follows:

1 (1) A baseline mammogram for women 35 to 39 years of
2 age.
3 (2) An annual mammogram for women 40 years of age or
4 older.
5 (3) A mammogram at the age and intervals considered
6 medically necessary by the woman's health care provider for
7 women under 40 years of age and having a family history of
8 breast cancer, prior personal history of breast cancer,
9 positive genetic testing, or other risk factors.
10 (4) A comprehensive ultrasound screening and MRI of an
11 entire breast or breasts if a mammogram demonstrates
12 heterogeneous or dense breast tissue, when medically
13 necessary as determined by a physician licensed to practice
14 medicine in all of its branches.
15 For purposes of this Section, "low-dose mammography" means
16 the x-ray examination of the breast using equipment dedicated
17 specifically for mammography, including the x-ray tube,
18 filter, compression device, and image receptor, with radiation
19 exposure delivery of less than 1 rad per breast for 2 views of
20 an average size breast. The term also includes digital
21 mammography and includes breast tomosynthesis. As used in this
22 Section, the term "breast tomosynthesis" means a radiologic
23 procedure that involves the acquisition of projection images
24 over the stationary breast to produce cross-sectional digital
25 three-dimensional images of the breast.
26 If, at any time, the Secretary of the United States

1 Department of Health and Human Services, or its successor
2 agency, promulgates rules or regulations to be published in the
3 Federal Register or publishes a comment in the Federal Register
4 or issues an opinion, guidance, or other action that would
5 require the State, pursuant to any provision of the Patient
6 Protection and Affordable Care Act (Public Law 111-148),
7 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
8 successor provision, to defray the cost of any coverage for
9 breast tomosynthesis outlined in this subsection, then the
10 requirement that an insurer cover breast tomosynthesis is
11 inoperative other than any such coverage authorized under
12 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
13 the State shall not assume any obligation for the cost of
14 coverage for breast tomosynthesis set forth in this subsection.
15 (a-5) Coverage as described in subsection (a) shall be
16 provided at no cost to the enrollee and shall not be applied to
17 an annual or lifetime maximum benefit.
18 (b) No contract or evidence of coverage issued by a health
19 maintenance organization that provides for the surgical
20 procedure known as a mastectomy shall be issued, amended,
21 delivered, or renewed in this State on or after the effective
22 date of this amendatory Act of the 92nd General Assembly unless
23 that coverage also provides for prosthetic devices or
24 reconstructive surgery incident to the mastectomy, providing
25 that the mastectomy is performed after the effective date of
26 this amendatory Act. Coverage for breast reconstruction in

1 connection with a mastectomy shall include:
2 (1) reconstruction of the breast upon which the
3 mastectomy has been performed;
4 (2) surgery and reconstruction of the other breast to
5 produce a symmetrical appearance; and
6 (3) prostheses and treatment for physical
7 complications at all stages of mastectomy, including
8 lymphedemas.
9 Care shall be determined in consultation with the attending
10 physician and the patient. The offered coverage for prosthetic
11 devices and reconstructive surgery shall be subject to the
12 deductible and coinsurance conditions applied to the
13 mastectomy and all other terms and conditions applicable to
14 other benefits. When a mastectomy is performed and there is no
15 evidence of malignancy, then the offered coverage may be
16 limited to the provision of prosthetic devices and
17 reconstructive surgery to within 2 years after the date of the
18 mastectomy. As used in this Section, "mastectomy" means the
19 removal of all or part of the breast for medically necessary
20 reasons, as determined by a licensed physician.
21 Written notice of the availability of coverage under this
22 Section shall be delivered to the enrollee upon enrollment and
23 annually thereafter. A health maintenance organization may not
24 deny to an enrollee eligibility, or continued eligibility, to
25 enroll or to renew coverage under the terms of the plan solely
26 for the purpose of avoiding the requirements of this Section. A

health maintenance organization may not penalize or reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with this Section.

(c) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-407 (see Section 20 of P.A. 99-588 for the effective date of P.A. 99-407); 99-588, eff. 7-20-16.)

Section 15. The Illinois Public Aid Code is amended by changing Section 5-5 as follows:

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home

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 and MRI of an
3 entire 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. If, at any time, the Secretary of the United States
25 Department of Health and Human Services, or its successor
26 agency, promulgates rules or regulations to be published in the

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

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

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

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

26 On and after January 1, 2017, providers participating in a

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

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

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

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

1 evaluation.

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

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

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

1 for patients diagnosed with cancer to at least one academic
2 commission on cancer-accredited cancer program as an
3 in-network covered benefit.

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

16 All medical providers providing medical assistance to
17 pregnant women under this Code shall receive information from
18 the Department on the availability of services under the Drug
19 Free Families with a Future or any comparable program providing
20 case management services for addicted women, including
21 information on appropriate referrals for other social services
22 that may be needed by addicted women in addition to treatment
23 for addiction.

24 The Illinois Department, in cooperation with the
25 Departments of Human Services (as successor to the Department
26 of Alcoholism and Substance Abuse) and Public Health, through a

1 public awareness campaign, may provide information concerning
2 treatment for alcoholism and drug abuse and addiction, prenatal
3 health care, and other pertinent programs directed at reducing
4 the number of drug-affected infants born to recipients of
5 medical assistance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 The Illinois Department shall establish policies,
24 procedures, standards and criteria by rule for the acquisition,
25 repair and replacement of orthotic and prosthetic devices and
26 durable medical equipment. Such rules shall provide, but not be

1 limited to, the following services: (1) immediate repair or
2 replacement of such devices by recipients; and (2) rental,
3 lease, purchase or lease-purchase of durable medical equipment
4 in a cost-effective manner, taking into consideration the
5 recipient's medical prognosis, the extent of the recipient's
6 needs, and the requirements and costs for maintaining such
7 equipment. Subject to prior approval, such rules shall enable a
8 recipient to temporarily acquire and use alternative or
9 substitute devices or equipment pending repairs or
10 replacements of any device or equipment previously authorized
11 for such recipient by the Department. Notwithstanding any
12 provision of Section 5-5f to the contrary, the Department may,
13 by rule, exempt certain replacement wheelchair parts from prior
14 approval and, for wheelchairs, wheelchair parts, wheelchair
15 accessories, and related seating and positioning items,
16 determine the wholesale price by methods other than actual
17 acquisition costs.

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

26 The Department shall execute, relative to the nursing home

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

1 not restrict the Department from implementing lower level of
2 care eligibility criteria for community-based services in
3 circumstances where federal approval has been granted.
4 The Illinois Department shall develop and operate, in
5 cooperation with other State Departments and agencies and in
6 compliance with applicable federal laws and regulations,
7 appropriate and effective systems of health care evaluation and
8 programs for monitoring of utilization of health care services
9 and facilities, as it affects persons eligible for medical
10 assistance under this Code.
11 The Illinois Department shall report annually to the
12 General Assembly, no later than the second Friday in April of
13 1979 and each year thereafter, in regard to:
14 (a) actual statistics and trends in utilization of
15 medical services by public aid recipients;
16 (b) actual statistics and trends in the provision of
17 the various medical services by medical vendors;
18 (c) current rate structures and proposed changes in
19 those rate structures for the various medical vendors; and
20 (d) efforts at utilization review and control by the
21 Illinois Department.
22 The period covered by each report shall be the 3 years
23 ending on the June 30 prior to the report. The report shall
24 include suggested legislation for consideration by the General
25 Assembly. The filing of one copy of the report with the
26 Speaker, one copy with the Minority Leader and one copy with

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

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

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

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

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

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

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

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

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

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 20 of P.A. 99-588 for the effective date of P.A. 99-407);
25 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff.
26 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895,

1 eff. 1-1-17; revised 9-20-16.)