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 Counties Code is amended by changing Section
5 5-1069 as follows:

6 (55 ILCS 5/5-1069) (from Ch. 34, par. 5-1069)
7 Sec. 5-1069. Group life, health, accident, hospital, and
8 medical insurance.
9 (a) The county board of any county may arrange to provide,
10 for the benefit of employees of the county, group life, health,
11 accident, hospital, and medical insurance, or any one or any
12 combination of those types of insurance, or the county board
13 may self-insure, for the benefit of its employees, all or a
14 portion of the employees' group life, health, accident,
15 hospital, and medical insurance, or any one or any combination
16 of those types of insurance, including a combination of
17 self-insurance and other types of insurance authorized by this
18 Section, provided that the county board complies with all other
19 requirements of this Section. The insurance may include
20 provision for employees who rely on treatment by prayer or
21 spiritual means alone for healing in accordance with the tenets
22 and practice of a well recognized religious denomination. The
23 county board may provide for payment by the county of a portion

1 or all of the premium or charge for the insurance with the
2 employee paying the balance of the premium or charge, if any.
3 If the county board undertakes a plan under which the county
4 pays only a portion of the premium or charge, the county board
5 shall provide for withholding and deducting from the
6 compensation of those employees who consent to join the plan
7 the balance of the premium or charge for the insurance.

8 (b) If the county board does not provide for self-insurance
9 or for a plan under which the county pays a portion or all of
10 the premium or charge for a group insurance plan, the county
11 board may provide for withholding and deducting from the
12 compensation of those employees who consent thereto the total
13 premium or charge for any group life, health, accident,
14 hospital, and medical insurance.

15 (c) The county board may exercise the powers granted in
16 this Section only if it provides for self-insurance or, where
17 it makes arrangements to provide group insurance through an
18 insurance carrier, if the kinds of group insurance are obtained
19 from an insurance company authorized to do business in the
20 State of Illinois. The county board may enact an ordinance
21 prescribing the method of operation of the insurance program.

22 (d) If a county, including a home rule county, is a
23 self-insurer for purposes of providing health insurance
24 coverage for its employees, the insurance coverage shall
25 include screening by low-dose mammography for all women 35
26 years of age or older for the presence of occult breast cancer

unless the county elects to provide mammograms itself under Section 5-1069.1. The coverage shall be as follows:

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

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

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

(4) For a group policy of accident and health insurance that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly, a ~~A~~ comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or~~,~~ when medically necessary as determined by a physician licensed to practice medicine in all of its branches, advanced practice registered nurse, or physician assistant.

(5) For a group policy of accident and health insurance that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly, a diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice

registered nurse, or physician assistant.

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

For purposes of this subsection:~~,~~

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

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

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

(d-5) Coverage as described by subsection (d) shall be provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit.

1 (d-10) When health care services are available through
2 contracted providers and a person does not comply with plan
3 provisions specific to the use of contracted providers, the
4 requirements of subsection (d-5) are not applicable. When a
5 person does not comply with plan provisions specific to the use
6 of contracted providers, plan provisions specific to the use of
7 non-contracted providers must be applied without distinction
8 for coverage required by this Section and shall be at least as
9 favorable as for other radiological examinations covered by the
10 policy or contract.

11 (d-15) If a county, including a home rule county, is a
12 self-insurer for purposes of providing health insurance
13 coverage for its employees, the insurance coverage shall
14 include mastectomy coverage, which includes coverage for
15 prosthetic devices or reconstructive surgery incident to the
16 mastectomy. Coverage for breast reconstruction in connection
17 with a mastectomy shall include:

18 (1) reconstruction of the breast upon which the
19 mastectomy has been performed;

20 (2) surgery and reconstruction of the other breast to
21 produce a symmetrical appearance; and

22 (3) prostheses and treatment for physical
23 complications at all stages of mastectomy, including
24 lymphedemas.

25 Care shall be determined in consultation with the attending
26 physician and the patient. The offered coverage for prosthetic

devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to other benefits. When a mastectomy is performed and there is no evidence of malignancy then the offered coverage may be limited to the provision of prosthetic devices and reconstructive surgery to within 2 years after the date of the mastectomy. As used in this Section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician.

A county, including a home rule county, that is a self-insurer for purposes of providing health insurance coverage for its employees, 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.

(d-20) The requirement that mammograms be included in health insurance coverage as provided in subsections (d) through (d-15) is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution of home rule county powers. A home rule county to which subsections (d) through (d-15) apply must comply with every provision of those subsections.

(e) The term "employees" as used in this Section includes

elected or appointed officials but does not include temporary employees.

(f) The county board may, by ordinance, arrange to provide group life, health, accident, hospital, and medical insurance, or any one or a combination of those types of insurance, under this Section to retired former employees and retired former elected or appointed officials of the county.

(g) 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. 99-581, eff. 1-1-17; 100-513, eff. 1-1-18.)

Section 10. The Illinois Municipal Code is amended by changing Section 10-4-2 as follows:

(65 ILCS 5/10-4-2) (from Ch. 24, par. 10-4-2)

Sec. 10-4-2. Group insurance.

(a) The corporate authorities of any municipality may arrange to provide, for the benefit of employees of the municipality, group life, health, accident, hospital, and medical insurance, or any one or any combination of those types of insurance, and may arrange to provide that insurance for the

1 benefit of the spouses or dependents of those employees. The
2 insurance may include provision for employees or other insured
3 persons who rely on treatment by prayer or spiritual means
4 alone for healing in accordance with the tenets and practice of
5 a well recognized religious denomination. The corporate
6 authorities may provide for payment by the municipality of a
7 portion of the premium or charge for the insurance with the
8 employee paying the balance of the premium or charge. If the
9 corporate authorities undertake a plan under which the
10 municipality pays a portion of the premium or charge, the
11 corporate authorities shall provide for withholding and
12 deducting from the compensation of those municipal employees
13 who consent to join the plan the balance of the premium or
14 charge for the insurance.

15 (b) If the corporate authorities do not provide for a plan
16 under which the municipality pays a portion of the premium or
17 charge for a group insurance plan, the corporate authorities
18 may provide for withholding and deducting from the compensation
19 of those employees who consent thereto the premium or charge
20 for any group life, health, accident, hospital, and medical
21 insurance.

22 (c) The corporate authorities may exercise the powers
23 granted in this Section only if the kinds of group insurance
24 are obtained from an insurance company authorized to do
25 business in the State of Illinois, or are obtained through an
26 intergovernmental joint self-insurance pool as authorized

under the Intergovernmental Cooperation Act. The corporate authorities may enact an ordinance prescribing the method of operation of the insurance program.

(d) If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the insurance coverage shall include screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer unless the municipality elects to provide mammograms itself under Section 10-4-2.1. The coverage shall be as follows:

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

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

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

(4) For a group policy of accident and health insurance that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly, a ~~A~~ comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or~~,~~ when medically necessary as determined by a physician licensed to practice

1 medicine in all of its branches.

2 (5) For a group policy of accident and health insurance
3 that is amended, delivered, issued, or renewed on or after
4 the effective date of this amendatory Act of the 101st
5 General Assembly, a diagnostic mammogram when medically
6 necessary, as determined by a physician licensed to
7 practice medicine in all its branches, advanced practice
8 registered nurse, or physician assistant.

9 A policy subject to this subsection shall not impose a
10 deductible, coinsurance, copayment, or any other cost-sharing
11 requirement on the coverage provided; except that this sentence
12 does not apply to coverage of diagnostic mammograms to the
13 extent such coverage would disqualify a high-deductible health
14 plan from eligibility for a health savings account pursuant to
15 Section 223 of the Internal Revenue Code (26 U.S.C. 223).

16 For purposes of this subsection:,

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

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

24 "Low-dose low-dose mammography" means the x-ray
25 examination of the breast using equipment dedicated
26 specifically for mammography, including the x-ray tube,

filter, compression device, and image receptor, with an average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography.

(d-5) Coverage as described by subsection (d) shall be provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit.

(d-10) When health care services are available through contracted providers and a person does not comply with plan provisions specific to the use of contracted providers, the requirements of subsection (d-5) are not applicable. When a person does not comply with plan provisions specific to the use of contracted providers, plan provisions specific to the use of non-contracted providers must be applied without distinction for coverage required by this Section and shall be at least as favorable as for other radiological examinations covered by the policy or contract.

(d-15) If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the insurance coverage shall include mastectomy coverage, which includes coverage for prosthetic devices or reconstructive surgery incident to the mastectomy. Coverage for breast reconstruction in connection with a mastectomy shall include:

(1) reconstruction of the breast upon which the mastectomy has been performed;

1 (2) surgery and reconstruction of the other breast to
2 produce a symmetrical appearance; and
3 (3) prostheses and treatment for physical
4 complications at all stages of mastectomy, including
5 lymphedemas.
6 Care shall be determined in consultation with the attending
7 physician and the patient. The offered coverage for prosthetic
8 devices and reconstructive surgery shall be subject to the
9 deductible and coinsurance conditions applied to the
10 mastectomy, and all other terms and conditions applicable to
11 other benefits. When a mastectomy is performed and there is no
12 evidence of malignancy then the offered coverage may be limited
13 to the provision of prosthetic devices and reconstructive
14 surgery to within 2 years after the date of the mastectomy. As
15 used in this Section, "mastectomy" means the removal of all or
16 part of the breast for medically necessary reasons, as
17 determined by a licensed physician.
18 A municipality, including a home rule municipality, that is
19 a self-insurer for purposes of providing health insurance
20 coverage for its employees, may not penalize or reduce or limit
21 the reimbursement of an attending provider or provide
22 incentives (monetary or otherwise) to an attending provider to
23 induce the provider to provide care to an insured in a manner
24 inconsistent with this Section.
25 (d-20) The requirement that mammograms be included in
26 health insurance coverage as provided in subsections (d)

1 through (d-15) is an exclusive power and function of the State
2 and is a denial and limitation under Article VII, Section 6,
3 subsection (h) of the Illinois Constitution of home rule
4 municipality powers. A home rule municipality to which
5 subsections (d) through (d-15) apply must comply with every
6 provision of those subsections.

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

13 (Source: P.A. 100-863, eff. 8-14-18.)

14 Section 15. The Illinois Insurance Code is amended by
15 changing Section 356g as follows:

16 (215 ILCS 5/356g) (from Ch. 73, par. 968g)

17 Sec. 356g. Mammograms; mastectomies.

18 (a) Every insurer shall provide in each group or individual
19 policy, contract, or certificate of insurance issued or renewed
20 for persons who are residents of this State, coverage for
21 screening by low-dose mammography for all women 35 years of age
22 or older for the presence of occult breast cancer within the
23 provisions of the policy, contract, or certificate. The
24 coverage shall be as 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) For an individual or group policy of accident and
11 health insurance or a managed care plan that is amended,
12 delivered, issued, or renewed on or after the effective
13 date of this amendatory Act of the 101st General Assembly,
14 a ~~A~~ comprehensive ultrasound screening and MRI of an entire
15 breast or breasts if a mammogram demonstrates
16 heterogeneous or dense breast tissue or~~,~~ when medically
17 necessary as determined by a physician licensed to practice
18 medicine in all of its branches.
19 (5) A screening MRI when medically necessary, as
20 determined by a physician licensed to practice medicine in
21 all of its branches.
22 (6) For an individual or group policy of accident and
23 health insurance or a managed care plan that is amended,
24 delivered, issued, or renewed on or after the effective
25 date of this amendatory Act of the 101st General Assembly,
26 a diagnostic mammogram when medically necessary, as

1 determined by a physician licensed to practice medicine in
2 all its branches, advanced practice registered nurse, or
3 physician assistant.
4 A policy subject to this subsection shall not impose a
5 deductible, coinsurance, copayment, or any other cost-sharing
6 requirement on the coverage provided; except that this sentence
7 does not apply to coverage of diagnostic mammograms to the
8 extent such coverage would disqualify a high-deductible health
9 plan from eligibility for a health savings account pursuant to
10 Section 223 of the Internal Revenue Code (26 U.S.C. 223).
11 For purposes of this Section:,
12 "Diagnostic mammogram" means a mammogram obtained using
13 diagnostic mammography.
14 "Diagnostic mammography" means a method of screening that
15 is designed to evaluate an abnormality in a breast, including
16 an abnormality seen or suspected on a screening mammogram or a
17 subjective or objective abnormality otherwise detected in the
18 breast.
19 "Low-dose low-dose mammography" means the x-ray
20 examination of the breast using equipment dedicated
21 specifically for mammography, including the x-ray tube,
22 filter, compression device, and image receptor, with radiation
23 exposure delivery of less than 1 rad per breast for 2 views of
24 an average size breast. The term also includes digital
25 mammography and includes breast tomosynthesis. As used in this
26 Section, the term "breast tomosynthesis" means a radiologic

1 procedure that involves the acquisition of projection images
2 over the stationary breast to produce cross-sectional digital
3 three-dimensional images of the breast.
4 If, at any time, the Secretary of the United States
5 Department of Health and Human Services, or its successor
6 agency, promulgates rules or regulations to be published in the
7 Federal Register or publishes a comment in the Federal Register
8 or issues an opinion, guidance, or other action that would
9 require the State, pursuant to any provision of the Patient
10 Protection and Affordable Care Act (Public Law 111-148),
11 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
12 successor provision, to defray the cost of any coverage for
13 breast tomosynthesis outlined in this subsection, then the
14 requirement that an insurer cover breast tomosynthesis is
15 inoperative other than any such coverage authorized under
16 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
17 the State shall not assume any obligation for the cost of
18 coverage for breast tomosynthesis set forth in this subsection.
19 (a-5) Coverage as described by subsection (a) shall be
20 provided at no cost to the insured and shall not be applied to
21 an annual or lifetime maximum benefit.
22 (a-10) When health care services are available through
23 contracted providers and a person does not comply with plan
24 provisions specific to the use of contracted providers, the
25 requirements of subsection (a-5) are not applicable. When a
26 person does not comply with plan provisions specific to the use

of contracted providers, plan provisions specific to the use of non-contracted providers must be applied without distinction for coverage required by this Section and shall be at least as favorable as for other radiological examinations covered by the policy or contract.

(b) No policy of accident or health insurance that provides for the surgical procedure known as a mastectomy shall be issued, amended, delivered, or renewed in this State unless that coverage also provides for prosthetic devices or reconstructive surgery incident to the mastectomy. Coverage for breast reconstruction in connection with a mastectomy shall include:

(1) reconstruction of the breast upon which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and treatment for physical complications at all stages of mastectomy, including lymphedemas.

Care shall be determined in consultation with the attending physician and the patient. The offered coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to other benefits. When a mastectomy is performed and there is no evidence of malignancy then the offered coverage may be limited

to the provision of prosthetic devices and reconstructive surgery to within 2 years after the date of the mastectomy. As used in this Section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician.

Written notice of the availability of coverage under this Section shall be delivered to the insured upon enrollment and annually thereafter. An insurer may not deny to an insured eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this Section. An insurer 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 Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-407 (see Section 20 of P.A. 99-588 for the effective date of P.A. 99-407); 99-433, eff. 8-21-15; 99-588, eff. 7-20-16; 99-642, eff. 7-28-16; 100-395, eff. 1-1-18.)

Section 20. The Health Maintenance Organization Act is

amended by changing Section 4-6.1 as follows:

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

Sec. 4-6.1. Mammograms; mastectomies.

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

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

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

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

(4) For an individual or group policy of accident and health insurance or a managed care plan that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 101st General Assembly, a ~~A~~ comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or~~,~~ when medically

1 necessary as determined by a physician licensed to practice
2 medicine in all of its branches.
3 (5) For an individual or group policy of accident and
4 health insurance or a managed care plan that is amended,
5 delivered, issued, or renewed on or after the effective
6 date of this amendatory Act of the 101st General Assembly,
7 a diagnostic mammogram when medically necessary, as
8 determined by a physician licensed to practice medicine in
9 all its branches, advanced practice registered nurse, or
10 physician assistant.
11 A policy subject to this subsection shall not impose a
12 deductible, coinsurance, copayment, or any other cost-sharing
13 requirement on the coverage provided; except that this sentence
14 does not apply to coverage of diagnostic mammograms to the
15 extent such coverage would disqualify a high-deductible health
16 plan from eligibility for a health savings account pursuant to
17 Section 223 of the Internal Revenue Code (26 U.S.C. 223).
18 For purposes of this Section:,
19 "Diagnostic mammogram" means a mammogram obtained using
20 diagnostic mammography.
21 "Diagnostic mammography" means a method of screening that
22 is designed to evaluate an abnormality in a breast, including
23 an abnormality seen or suspected on a screening mammogram or a
24 subjective or objective abnormality otherwise detected in the
25 breast.
26 "Low-dose low-dose mammography" means the x-ray

examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis.

"Breast As used in this Section, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

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

(a-5) Coverage as described in subsection (a) shall be provided at no cost to the enrollee and shall not be applied to an annual or lifetime maximum benefit.

(b) No contract or evidence of coverage issued by a health maintenance organization that provides for the surgical procedure known as a mastectomy shall be issued, amended, delivered, or renewed in this State on or after the effective date of this amendatory Act of the 92nd General Assembly unless that coverage also provides for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that the mastectomy is performed after the effective date of this amendatory Act. Coverage for breast reconstruction in connection with a mastectomy shall include:

(1) reconstruction of the breast upon which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and treatment for physical complications at all stages of mastectomy, including lymphedemas.

Care shall be determined in consultation with the attending physician and the patient. The offered coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits. When a mastectomy is performed and there is no

1 evidence of malignancy, then the offered coverage may be
2 limited to the provision of prosthetic devices and
3 reconstructive surgery to within 2 years after the date of the
4 mastectomy. As used in this Section, "mastectomy" means the
5 removal of all or part of the breast for medically necessary
6 reasons, as determined by a licensed physician.

7 Written notice of the availability of coverage under this
8 Section shall be delivered to the enrollee upon enrollment and
9 annually thereafter. A health maintenance organization may not
10 deny to an enrollee eligibility, or continued eligibility, to
11 enroll or to renew coverage under the terms of the plan solely
12 for the purpose of avoiding the requirements of this Section. A
13 health maintenance organization may not penalize or reduce or
14 limit the reimbursement of an attending provider or provide
15 incentives (monetary or otherwise) to an attending provider to
16 induce the provider to provide care to an insured in a manner
17 inconsistent with this Section.

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

25 (Source: P.A. 99-407 (see Section 20 of P.A. 99-588 for the
26 effective date of P.A. 99-407); 99-588, eff. 7-20-16; 100-395,

eff. 1-1-18.)

Section 25. The Illinois Public Aid Code is amended by changing Section 5-5 as follows:

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

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

1 prosthetic devices; and eyeglasses prescribed by a physician
2 skilled in the diseases of the eye, or by an optometrist,
3 whichever the person may select; (13) other diagnostic,
4 screening, preventive, and rehabilitative services, including
5 to ensure that the individual's need for intervention or
6 treatment of mental disorders or substance use disorders or
7 co-occurring mental health and substance use disorders is
8 determined using a uniform screening, assessment, and
9 evaluation process inclusive of criteria, for children and
10 adults; for purposes of this item (13), a uniform screening,
11 assessment, and evaluation process refers to a process that
12 includes an appropriate evaluation and, as warranted, a
13 referral; "uniform" does not mean the use of a singular
14 instrument, tool, or process that all must utilize; (14)
15 transportation and such other expenses as may be necessary;
16 (15) medical treatment of sexual assault survivors, as defined
17 in Section 1a of the Sexual Assault Survivors Emergency
18 Treatment Act, for injuries sustained as a result of the sexual
19 assault, including examinations and laboratory tests to
20 discover evidence which may be used in criminal proceedings
21 arising from the sexual assault; (16) the diagnosis and
22 treatment of sickle cell anemia; and (17) any other medical
23 care, and any other type of remedial care recognized under the
24 laws of this State. The term "any other type of remedial care"
25 shall include nursing care and nursing home service for persons
26 who rely on treatment by spiritual means alone through prayer

1 for healing.
2 Notwithstanding any other provision of this Section, a
3 comprehensive tobacco use cessation program that includes
4 purchasing prescription drugs or prescription medical devices
5 approved by the Food and Drug Administration shall be covered
6 under the medical assistance program under this Article for
7 persons who are otherwise eligible for assistance under this
8 Article.
9 Notwithstanding any other provision of this Code,
10 reproductive health care that is otherwise legal in Illinois
11 shall be covered under the medical assistance program for
12 persons who are otherwise eligible for medical assistance under
13 this Article.
14 Notwithstanding any other provision of this Code, the
15 Illinois Department may not require, as a condition of payment
16 for any laboratory test authorized under this Article, that a
17 physician's handwritten signature appear on the laboratory
18 test order form. The Illinois Department may, however, impose
19 other appropriate requirements regarding laboratory test order
20 documentation.
21 Upon receipt of federal approval of an amendment to the
22 Illinois Title XIX State Plan for this purpose, the Department
23 shall authorize the Chicago Public Schools (CPS) to procure a
24 vendor or vendors to manufacture eyeglasses for individuals
25 enrolled in a school within the CPS system. CPS shall ensure
26 that its vendor or vendors are enrolled as providers in the

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

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

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

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

On and after July 1, 2018, the Department of Healthcare and Family Services shall provide dental services to any adult who is otherwise eligible for assistance under the medical

assistance program. As used in this paragraph, "dental services" means diagnostic, preventative, restorative, or corrective procedures, including procedures and services for the prevention and treatment of periodontal disease and dental caries disease, provided by an individual who is licensed to practice dentistry or dental surgery or who is under the supervision of a dentist in the practice of his or her profession.

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

Notwithstanding any other provision of this Code and subject to federal approval, the Department may adopt rules to allow a dentist who is volunteering his or her service at no cost to render dental services through an enrolled not-for-profit health clinic without the dentist personally enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other

1 enrolled provider, as determined by the Department, through
2 which dental services covered under this Section are performed.
3 The Department shall establish a process for payment of claims
4 for reimbursement for covered dental services rendered under
5 this provision.

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

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

16 The Illinois Department shall authorize the provision of,
17 and shall authorize payment for, screening by low-dose
18 mammography for the presence of occult breast cancer for women
19 35 years of age or older who are eligible for medical
20 assistance under this Article, as follows:

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

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

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

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

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

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

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

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

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

tool.

For purposes of this Section:~~,~~

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

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

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

"Breast ~~As used in this Section, the term "breast~~ tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would

1 require the State, pursuant to any provision of the Patient
2 Protection and Affordable Care Act (Public Law 111-148),
3 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
4 successor provision, to defray the cost of any coverage for
5 breast tomosynthesis outlined in this paragraph, then the
6 requirement that an insurer cover breast tomosynthesis is
7 inoperative other than any such coverage authorized under
8 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
9 the State shall not assume any obligation for the cost of
10 coverage for breast tomosynthesis set forth in this paragraph.
11 On and after January 1, 2016, the Department shall ensure
12 that all networks of care for adult clients of the Department
13 include access to at least one breast imaging Center of Imaging
14 Excellence as certified by the American College of Radiology.
15 On and after January 1, 2012, providers participating in a
16 quality improvement program approved by the Department shall be
17 reimbursed for screening and diagnostic mammography at the same
18 rate as the Medicare program's rates, including the increased
19 reimbursement for digital mammography.
20 The Department shall convene an expert panel including
21 representatives of hospitals, free-standing mammography
22 facilities, and doctors, including radiologists, to establish
23 quality standards for mammography.
24 On and after January 1, 2017, providers participating in a
25 breast cancer treatment quality improvement program approved
26 by the Department shall be reimbursed for breast cancer

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

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

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

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

26 The Department shall establish a performance goal for

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

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

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

in-network covered benefit.

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

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

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

medical assistance.

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

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

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

The sponsor must negotiate formal written contracts with medical providers for physician services, inpatient and outpatient hospital care, home health services, treatment for alcoholism and substance abuse, and other services determined

necessary by the Illinois Department by rule for delivery by Partnerships. Physician services must include prenatal and obstetrical care. The Illinois Department shall reimburse medical services delivered by Partnership providers to clients in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

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

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

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

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

1 written approval of the Illinois Department.
2 Nothing in this Section shall limit the free choice of
3 practitioners, hospitals, and other providers of medical
4 services by clients. In order to ensure patient freedom of
5 choice, the Illinois Department shall immediately promulgate
6 all rules and take all other necessary actions so that provided
7 services may be accessed from therapeutically certified
8 optometrists to the full extent of the Illinois Optometric
9 Practice Act of 1987 without discriminating between service
10 providers.
11 The Department shall apply for a waiver from the United
12 States Health Care Financing Administration to allow for the
13 implementation of Partnerships under this Section.
14 The Illinois Department shall require health care
15 providers to maintain records that document the medical care
16 and services provided to recipients of Medical Assistance under
17 this Article. Such records must be retained for a period of not
18 less than 6 years from the date of service or as provided by
19 applicable State law, whichever period is longer, except that
20 if an audit is initiated within the required retention period
21 then the records must be retained until the audit is completed
22 and every exception is resolved. The Illinois Department shall
23 require health care providers to make available, when
24 authorized by the patient, in writing, the medical records in a
25 timely fashion to other health care providers who are treating
26 or serving persons eligible for Medical Assistance under this

1 Article. All dispensers of medical services shall be required
2 to maintain and retain business and professional records
3 sufficient to fully and accurately document the nature, scope,
4 details and receipt of the health care provided to persons
5 eligible for medical assistance under this Code, in accordance
6 with regulations promulgated by the Illinois Department. The
7 rules and regulations shall require that proof of the receipt
8 of prescription drugs, dentures, prosthetic devices and
9 eyeglasses by eligible persons under this Section accompany
10 each claim for reimbursement submitted by the dispenser of such
11 medical services. No such claims for reimbursement shall be
12 approved for payment by the Illinois Department without such
13 proof of receipt, unless the Illinois Department shall have put
14 into effect and shall be operating a system of post-payment
15 audit and review which shall, on a sampling basis, be deemed
16 adequate by the Illinois Department to assure that such drugs,
17 dentures, prosthetic devices and eyeglasses for which payment
18 is being made are actually being received by eligible
19 recipients. Within 90 days after September 16, 1984 (the
20 effective date of Public Act 83-1439), the Illinois Department
21 shall establish a current list of acquisition costs for all
22 prosthetic devices and any other items recognized as medical
23 equipment and supplies reimbursable under this Article and
24 shall update such list on a quarterly basis, except that the
25 acquisition costs of all prescription drugs shall be updated no
26 less frequently than every 30 days as required by Section

5-5.12.

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

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

The Illinois Department shall require all dispensers of medical services, other than an individual practitioner or group of practitioners, desiring to participate in the Medical Assistance program established under this Article to disclose

1 all financial, beneficial, ownership, equity, surety or other
2 interests in any and all firms, corporations, partnerships,
3 associations, business enterprises, joint ventures, agencies,
4 institutions or other legal entities providing any form of
5 health care services in this State under this Article.

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

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

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

26 Prior to enrollment and during the conditional enrollment

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

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

22 To be eligible for payment consideration, a vendor's
23 payment claim or bill, either as an initial claim or as a
24 resubmitted claim following prior rejection, must be received
25 by the Illinois Department, or its fiscal intermediary, no
26 later than 180 days after the latest date on the claim on which

medical goods or services were provided, with the following exceptions:

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

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

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

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

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

In the case of long term care facilities, within 45

1 calendar days of receipt by the facility of required
2 prescreening information, new admissions with associated
3 admission documents shall be submitted through the Medical
4 Electronic Data Interchange (MEDI) or the Recipient
5 Eligibility Verification (REV) System or shall be submitted
6 directly to the Department of Human Services using required
7 admission forms. Effective September 1, 2014, admission
8 documents, including all prescreening information, must be
9 submitted through MEDI or REV. Confirmation numbers assigned to
10 an accepted transaction shall be retained by a facility to
11 verify timely submittal. Once an admission transaction has been
12 completed, all resubmitted claims following prior rejection
13 are subject to receipt no later than 180 days after the
14 admission transaction has been completed.

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

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

reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

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

Beginning in fiscal year 2013, the Illinois Department shall set forth a request for information to identify the benefits of a pre-payment, post-adjudication, and post-edit claims system with the goals of streamlining claims processing

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

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

1 by rule, exempt certain replacement wheelchair parts from prior
2 approval and, for wheelchairs, wheelchair parts, wheelchair
3 accessories, and related seating and positioning items,
4 determine the wholesale price by methods other than actual
5 acquisition costs.

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

14 In order to promote environmental responsibility, meet the
15 needs of recipients and enrollees, and achieve significant cost
16 savings, the Department, or a managed care organization under
17 contract with the Department, may provide recipients or managed
18 care enrollees who have a prescription or Certificate of
19 Medical Necessity access to refurbished durable medical
20 equipment under this Section (excluding prosthetic and
21 orthotic devices as defined in the Orthotics, Prosthetics, and
22 Pedorthics Practice Act and complex rehabilitation technology
23 products and associated services) through the State's
24 assistive technology program's reutilization program, using
25 staff with the Assistive Technology Professional (ATP)
26 Certification if the refurbished durable medical equipment:

1 (i) is available; (ii) is less expensive, including shipping
2 costs, than new durable medical equipment of the same type;
3 (iii) is able to withstand at least 3 years of use; (iv) is
4 cleaned, disinfected, sterilized, and safe in accordance with
5 federal Food and Drug Administration regulations and guidance
6 governing the reprocessing of medical devices in health care
7 settings; and (v) equally meets the needs of the recipient or
8 enrollee. The reutilization program shall confirm that the
9 recipient or enrollee is not already in receipt of same or
10 similar equipment from another service provider, and that the
11 refurbished durable medical equipment equally meets the needs
12 of the recipient or enrollee. Nothing in this paragraph shall
13 be construed to limit recipient or enrollee choice to obtain
14 new durable medical equipment or place any additional prior
15 authorization conditions on enrollees of managed care
16 organizations.

17 The Department shall execute, relative to the nursing home
18 prescreening project, written inter-agency agreements with the
19 Department of Human Services and the Department on Aging, to
20 effect the following: (i) intake procedures and common
21 eligibility criteria for those persons who are receiving
22 non-institutional services; and (ii) the establishment and
23 development of non-institutional services in areas of the State
24 where they are not currently available or are undeveloped; and
25 (iii) notwithstanding any other provision of law, subject to
26 federal approval, on and after July 1, 2012, an increase in the

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

21 The Illinois Department shall develop and operate, in
22 cooperation with other State Departments and agencies and in
23 compliance with applicable federal laws and regulations,
24 appropriate and effective systems of health care evaluation and
25 programs for monitoring of utilization of health care services
26 and facilities, as it affects persons eligible for medical

assistance under this Code.

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

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

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

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

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

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall include suggested legislation for consideration by the General Assembly. The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report as required by Section 3.1 of the General Assembly Organization Act, and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

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

1 whatever reason, is unauthorized.

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

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

23 Notwithstanding any other provision of this Code to the
24 contrary, on or after July 1, 2015, all FDA approved forms of
25 medication assisted treatment prescribed for the treatment of
26 alcohol dependence or treatment of opioid dependence shall be

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

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

20 Upon federal approval, the Department shall provide
21 coverage and reimbursement for all drugs that are approved for
22 marketing by the federal Food and Drug Administration and that
23 are recommended by the federal Public Health Service or the
24 United States Centers for Disease Control and Prevention for
25 pre-exposure prophylaxis and related pre-exposure prophylaxis
26 services, including, but not limited to, HIV and sexually

transmitted infection screening, treatment for sexually transmitted infections, medical monitoring, assorted labs, and counseling to reduce the likelihood of HIV infection among individuals who are not infected with HIV but who are at high risk of HIV infection.

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

Notwithstanding any other provision of this Code, the Illinois Department shall authorize licensed dietitian nutritionists and certified diabetes educators to counsel senior diabetes patients in the senior diabetes patients' homes to remove the hurdle of transportation for senior diabetes patients to receive treatment.

(Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for the effective date of P.A. 99-407); 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff.

1 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18;
2 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff.
3 12-10-18.)

4 Section 99. Effective date. This Act takes effect January
5 1, 2020.