

1 AN ACT concerning health.

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

4 Section 1. This Act may be referred to as the Improving
5 Health Care for Pregnant and Postpartum Individuals Act.

6 Section 5. The State Employees Group Insurance Act of 1971
7 is amended by changing Section 6.11 as follows:

8 (5 ILCS 375/6.11)

9 Sec. 6.11. Required health benefits; Illinois Insurance
10 Code requirements. The program of health benefits shall
11 provide the post-mastectomy care benefits required to be
12 covered by a policy of accident and health insurance under
13 Section 356t of the Illinois Insurance Code. The program of
14 health benefits shall provide the coverage required under
15 Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x,
16 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10,
17 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22,
18 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33,
19 356z.36, 356z.40, and 356z.41 of the Illinois Insurance Code.
20 The program of health benefits must comply with Sections
21 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 and Article
22 XXXIIB of the Illinois Insurance Code. The Department of

1 Insurance shall enforce the requirements of this Section with
2 respect to Sections 370c and 370c.1 of the Illinois Insurance
3 Code; all other requirements of this Section shall be enforced
4 by the Department of Central Management Services.

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

11 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
12 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff.
13 1-1-19; 100-1102, eff. 1-1-19; 100-1170, eff. 6-1-19; 101-13,
14 eff. 6-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20;
15 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff.
16 1-1-21.)

17 Section 10. The Department of Human Services Act is
18 amended by adding Section 10-23 as follows:

19 (20 ILCS 1305/10-23 new)

20 Sec. 10-23. High-risk pregnant or postpartum individuals.
21 The Department shall expand and update its maternal child
22 health programs to serve pregnant and postpartum individuals
23 determined to be high-risk using criteria established by a
24 multi-agency working group. The services shall be provided by

1 registered nurses, licensed social workers, or other staff
2 with behavioral health or medical training, as approved by the
3 Department. The persons providing the services may collaborate
4 with other providers, including, but not limited to,
5 obstetricians, gynecologists, or pediatricians, when providing
6 services to a patient.

7 Section 15. The Department of Public Health Powers and
8 Duties Law of the Civil Administrative Code of Illinois is
9 amended by renumbering and changing Section 2310-223, as added
10 by Public Act 101-390, and by adding Section 2310-470 as
11 follows:

12 (20 ILCS 2310/2310-222)

13 Sec. 2310-222 ~~2310-223~~. Obstetric hemorrhage and
14 hypertension training.

15 (a) As used in this Section:7

16 "Birthing ~~birthing~~ facility" means (1) a hospital, as
17 defined in the Hospital Licensing Act, with more than one
18 licensed obstetric bed or a neonatal intensive care unit; (2)
19 a hospital operated by a State university; or (3) a birth
20 center, as defined in the Alternative Health Care Delivery
21 Act.

22 "Postpartum" means the 12-month period after a person has
23 delivered a baby.

24 (b) The Department shall ensure that all birthing

1 facilities have a written policy and conduct continuing
2 education yearly for providers and staff of obstetric medicine
3 and of the emergency department and other staff that may care
4 for pregnant or postpartum women. The written policy and
5 continuing education shall include yearly educational modules
6 regarding management of severe maternal hypertension and
7 obstetric hemorrhage and other leading causes of maternal
8 mortality for units that care for pregnant or postpartum
9 women. Birthing facilities must demonstrate compliance with
10 these written policy, education, and training requirements.

11 (c) The Department shall collaborate with the Illinois
12 Perinatal Quality Collaborative or its successor organization
13 to develop an initiative to improve birth equity and reduce
14 peripartum racial and ethnic disparities. The Department shall
15 ensure that the initiative includes the development of best
16 practices for implicit bias training and education in cultural
17 competency to be used by birthing facilities in interactions
18 between patients and providers. In developing the initiative,
19 the Illinois Perinatal Quality Collaborative or its successor
20 organization shall consider existing programs, such as the
21 Alliance for Innovation on Maternal Health and the California
22 Maternal Quality Collaborative's pilot work on improving birth
23 equity. The Department shall support the initiation of a
24 statewide perinatal quality improvement initiative in
25 collaboration with birthing facilities to implement strategies
26 to reduce peripartum racial and ethnic disparities and to

1 address implicit bias in the health care system.

2 (d) In order to better facilitate continuity of care, the
3 ~~The~~ Department, in consultation with the Illinois Perinatal
4 Quality Collaborative Maternal Mortality Review Committee,
5 shall make available to all birthing facilities best practices
6 for timely identification and assessment of all pregnant and
7 postpartum women for common pregnancy or postpartum
8 complications in the emergency department and for care
9 provided by the birthing facility throughout the pregnancy and
10 postpartum period. The best practices shall include the
11 appropriate and timely consultation of an obstetric or other
12 relevant provider to provide input on management and
13 follow-up, such as offering coordination of a post-delivery
14 early postpartum visit or other services that may be
15 appropriate and available. Birthing facilities shall
16 incorporate these best practices into the written policy
17 required under subsection (b). Birthing facilities may use
18 telemedicine for the consultation.

19 (e) The Department may adopt rules for the purpose of
20 implementing this Section.

21 (Source: P.A. 101-390, eff. 1-1-20; revised 10-7-19.)

22 (20 ILCS 2310/2310-470 new)

23 Sec. 2310-470. High Risk Infant Follow-up. The Department,
24 in collaboration with the Department of Human Services, the
25 Department of Healthcare and Family Services, and other key

1 providers of maternal child health services, shall revise or
2 add to the rules of the Maternal and Child Health Services Code
3 (77 Ill. Adm. Code 630) that govern the High Risk Infant
4 Follow-up, using current scientific and national and State
5 outcomes data, to revise or expand existing services to
6 improve both maternal and infant outcomes overall and to
7 reduce racial disparities in outcomes and services provided.
8 The rules shall be revised or adopted on or before June 1,
9 2024.

10 Section 20. The Counties Code is amended by changing
11 Section 5-1069.3 as follows:

12 (55 ILCS 5/5-1069.3)

13 Sec. 5-1069.3. Required health benefits. If a county,
14 including a home rule county, is a self-insurer for purposes
15 of providing health insurance coverage for its employees, the
16 coverage shall include coverage for the post-mastectomy care
17 benefits required to be covered by a policy of accident and
18 health insurance under Section 356t and the coverage required
19 under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x,
20 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
21 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29,
22 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, and 356z.41 of
23 the Illinois Insurance Code. The coverage shall comply with
24 Sections 155.22a, 355b, 356z.19, and 370c of the Illinois

1 Insurance Code. The Department of Insurance shall enforce the
2 requirements of this Section. The requirement that health
3 benefits be covered as provided in this Section is an
4 exclusive power and function of the State and is a denial and
5 limitation under Article VII, Section 6, subsection (h) of the
6 Illinois Constitution. A home rule county to which this
7 Section applies must comply with every provision of 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 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
16 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff.
17 1-1-19; 100-1102, eff. 1-1-19; 101-81, eff. 7-12-19; 101-281,
18 eff. 1-1-20; 101-393, eff. 1-1-20; 101-461, eff. 1-1-20;
19 101-625, eff. 1-1-21.)

20 Section 25. The Illinois Municipal Code is amended by
21 changing Section 10-4-2.3 as follows:

22 (65 ILCS 5/10-4-2.3)

23 Sec. 10-4-2.3. Required health benefits. If a
24 municipality, including a home rule municipality, is a

1 self-insurer for purposes of providing health insurance
2 coverage for its employees, the coverage shall include
3 coverage for the post-mastectomy care benefits required to be
4 covered by a policy of accident and health insurance under
5 Section 356t and the coverage required under Sections 356g,
6 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9,
7 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22,
8 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33,
9 356z.36, 356z.40, and 356z.41 of the Illinois Insurance Code.
10 The coverage shall comply with Sections 155.22a, 355b,
11 356z.19, and 370c of the Illinois Insurance Code. The
12 Department of Insurance shall enforce the requirements of this
13 Section. The requirement that health benefits be covered as
14 provided in this is an exclusive power and function of the
15 State and is a denial and limitation under Article VII,
16 Section 6, subsection (h) of the Illinois Constitution. A home
17 rule municipality to which this Section applies must comply
18 with every provision of this Section.

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

25 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
26 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff.

1 1-1-19; 100-1102, eff. 1-1-19; 101-81, eff. 7-12-19; 101-281,
2 eff. 1-1-20; 101-393, eff. 1-1-20; 101-461, eff. 1-1-20;
3 101-625, eff. 1-1-21.)

4 Section 30. The School Code is amended by changing Section
5 10-22.3f as follows:

6 (105 ILCS 5/10-22.3f)

7 Sec. 10-22.3f. Required health benefits. Insurance
8 protection and benefits for employees shall provide the
9 post-mastectomy care benefits required to be covered by a
10 policy of accident and health insurance under Section 356t and
11 the coverage required under Sections 356g, 356g.5, 356g.5-1,
12 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12,
13 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29,
14 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, and 356z.41 of
15 the Illinois Insurance Code. Insurance policies shall comply
16 with Section 356z.19 of the Illinois Insurance Code. The
17 coverage shall comply with Sections 155.22a, 355b, and 370c of
18 the Illinois Insurance Code. The Department of Insurance shall
19 enforce the requirements of this Section.

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

1 whatever reason, is unauthorized.

2 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
3 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff.
4 1-1-19; 100-1102, eff. 1-1-19; 101-81, eff. 7-12-19; 101-281,
5 eff. 1-1-20; 101-393, eff. 1-1-20; 101-461, eff. 1-1-20;
6 101-625, eff. 1-1-21.)

7 Section 35. The Illinois Insurance Code is amended by
8 adding Sections 356z.4b and 356z.40 as follows:

9 (215 ILCS 5/356z.4b new)

10 Sec. 356z.4b. Billing for long-acting reversible
11 contraceptives.

12 (a) In this Section, "long-acting reversible contraceptive
13 device" means any intrauterine device or contraceptive
14 implant.

15 (b) Any individual or group policy of accident and health
16 insurance or qualified health plan that is offered through the
17 health insurance marketplace that is amended, delivered,
18 issued, or renewed on or after the effective date of this
19 amendatory Act of the 102nd General Assembly shall allow
20 hospitals separate reimbursement for a long-acting reversible
21 contraceptive device provided immediately postpartum in the
22 inpatient hospital setting before hospital discharge. The
23 payment shall be made in addition to a bundled or Diagnostic
24 Related Group reimbursement for labor and delivery.

1 (215 ILCS 5/356z.40 new)

2 Sec. 356z.40. Pregnancy and postpartum coverage.

3 (a) An individual or group policy of accident and health
4 insurance or managed care plan amended, delivered, issued, or
5 renewed on or after the effective date of this amendatory Act
6 of the 102nd General Assembly shall provide coverage for
7 pregnancy and newborn care in accordance with 42 U.S.C.
8 18022(b) regarding essential health benefits.

9 (b) Benefits under this Section shall be as follows:

10 (1) An individual who has been identified as
11 experiencing a high-risk pregnancy by the individual's
12 treating provider shall have access to clinically
13 appropriate case management programs. As used in this
14 subsection, "case management" means a mechanism to
15 coordinate and assure continuity of services, including,
16 but not limited to, health services, social services, and
17 educational services necessary for the individual. "Case
18 management" involves individualized assessment of needs,
19 planning of services, referral, monitoring, and advocacy
20 to assist an individual in gaining access to appropriate
21 services and closure when services are no longer required.
22 "Case management" is an active and collaborative process
23 involving a single qualified case manager, the individual,
24 the individual's family, the providers, and the community.
25 This includes close coordination and involvement with all

1 service providers in the management plan for that
2 individual or family, including assuring that the
3 individual receives the services. As used in this
4 subsection, "high-risk pregnancy" means a pregnancy in
5 which the pregnant or postpartum individual or baby is at
6 an increased risk for poor health or complications during
7 pregnancy or childbirth, including, but not limited to,
8 hypertension disorders, gestational diabetes, and
9 hemorrhage.

10 (2) An individual shall have access to medically
11 necessary treatment of a mental, emotional, nervous, or
12 substance use disorder or condition consistent with the
13 requirements set forth in this Section and in Sections
14 370c and 370c.1 of this Code.

15 (3) The benefits provided for inpatient and outpatient
16 services for the treatment of a mental, emotional,
17 nervous, or substance use disorder or condition related to
18 pregnancy or postpartum complications shall be provided if
19 determined to be medically necessary, consistent with the
20 requirements of Sections 370c and 370c.1 of this Code. The
21 facility or provider shall notify the insurer of both the
22 admission and the initial treatment plan within 48 hours
23 after admission or initiation of treatment. Nothing in
24 this paragraph shall prevent an insurer from applying
25 concurrent and post-service utilization review of health
26 care services, including review of medical necessity, case

1 management, experimental and investigational treatments,
2 managed care provisions, and other terms and conditions of
3 the insurance policy.

4 (4) The benefits for the first 48 hours of initiation
5 of services for an inpatient admission, detoxification or
6 withdrawal management program, or partial hospitalization
7 admission for the treatment of a mental, emotional,
8 nervous, or substance use disorder or condition related to
9 pregnancy or postpartum complications shall be provided
10 without post-service or concurrent review of medical
11 necessity, as the medical necessity for the first 48 hours
12 of such services shall be determined solely by the covered
13 pregnant or postpartum individual's provider. Nothing in
14 this paragraph shall prevent an insurer from applying
15 concurrent and post-service utilization review, including
16 the review of medical necessity, case management,
17 experimental and investigational treatments, managed care
18 provisions, and other terms and conditions of the
19 insurance policy, of any inpatient admission,
20 detoxification or withdrawal management program admission,
21 or partial hospitalization admission services for the
22 treatment of a mental, emotional, nervous, or substance
23 use disorder or condition related to pregnancy or
24 postpartum complications received 48 hours after the
25 initiation of such services. If an insurer determines that
26 the services are no longer medically necessary, then the

1 covered person shall have the right to external review
2 pursuant to the requirements of the Health Carrier
3 External Review Act.

4 (5) If an insurer determines that continued inpatient
5 care, detoxification or withdrawal management, partial
6 hospitalization, intensive outpatient treatment, or
7 outpatient treatment in a facility is no longer medically
8 necessary, the insurer shall, within 24 hours, provide
9 written notice to the covered pregnant or postpartum
10 individual and the covered pregnant or postpartum
11 individual's provider of its decision and the right to
12 file an expedited internal appeal of the determination.
13 The insurer shall review and make a determination with
14 respect to the internal appeal within 24 hours and
15 communicate such determination to the covered pregnant or
16 postpartum individual and the covered pregnant or
17 postpartum individual's provider. If the determination is
18 to uphold the denial, the covered pregnant or postpartum
19 individual and the covered pregnant or postpartum
20 individual's provider have the right to file an expedited
21 external appeal. An independent utilization review
22 organization shall make a determination within 72 hours.
23 If the insurer's determination is upheld and it is
24 determined that continued inpatient care, detoxification
25 or withdrawal management, partial hospitalization,
26 intensive outpatient treatment, or outpatient treatment is

1 not medically necessary, the insurer shall remain
2 responsible for providing benefits for the inpatient care,
3 detoxification or withdrawal management, partial
4 hospitalization, intensive outpatient treatment, or
5 outpatient treatment through the day following the date
6 the determination is made, and the covered pregnant or
7 postpartum individual shall only be responsible for any
8 applicable copayment, deductible, and coinsurance for the
9 stay through that date as applicable under the policy. The
10 covered pregnant or postpartum individual shall not be
11 discharged or released from the inpatient facility,
12 detoxification or withdrawal management, partial
13 hospitalization, intensive outpatient treatment, or
14 outpatient treatment until all internal appeals and
15 independent utilization review organization appeals are
16 exhausted. A decision to reverse an adverse determination
17 shall comply with the Health Carrier External Review Act.

18 (6) Except as otherwise stated in this subsection (b),
19 the benefits and cost-sharing shall be provided to the
20 same extent as for any other medical condition covered
21 under the policy.

22 (7) The benefits required by paragraphs (2) and (6) of
23 this subsection (b) are to be provided to all covered
24 pregnant or postpartum individuals with a diagnosis of a
25 mental, emotional, nervous, or substance use disorder or
26 condition. The presence of additional related or unrelated

1 diagnoses shall not be a basis to reduce or deny the
2 benefits required by this subsection (b).

3 Section 40. The Health Maintenance Organization Act is
4 amended by changing Section 5-3 as follows:

5 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

6 Sec. 5-3. Insurance Code provisions.

7 (a) Health Maintenance Organizations shall be subject to
8 the provisions of Sections 133, 134, 136, 137, 139, 140,
9 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,
10 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2,
11 355.3, 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2,
12 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10,
13 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18,
14 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30,
15 356z.30a, 356z.32, 356z.33, 356z.35, 356z.36, 356z.40,
16 356z.41, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c,
17 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408,
18 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection
19 (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2,
20 XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the Illinois
21 Insurance Code.

22 (b) For purposes of the Illinois Insurance Code, except
23 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
24 Health Maintenance Organizations in the following categories

1 are deemed to be "domestic companies":

2 (1) a corporation authorized under the Dental Service
3 Plan Act or the Voluntary Health Services Plans Act;

4 (2) a corporation organized under the laws of this
5 State; or

6 (3) a corporation organized under the laws of another
7 state, 30% or more of the enrollees of which are residents
8 of this State, except a corporation subject to
9 substantially the same requirements in its state of
10 organization as is a "domestic company" under Article VIII
11 1/2 of the Illinois Insurance Code.

12 (c) In considering the merger, consolidation, or other
13 acquisition of control of a Health Maintenance Organization
14 pursuant to Article VIII 1/2 of the Illinois Insurance Code,

15 (1) the Director shall give primary consideration to
16 the continuation of benefits to enrollees and the
17 financial conditions of the acquired Health Maintenance
18 Organization after the merger, consolidation, or other
19 acquisition of control takes effect;

20 (2) (i) the criteria specified in subsection (1) (b) of
21 Section 131.8 of the Illinois Insurance Code shall not
22 apply and (ii) the Director, in making his determination
23 with respect to the merger, consolidation, or other
24 acquisition of control, need not take into account the
25 effect on competition of the merger, consolidation, or
26 other acquisition of control;

1 (3) the Director shall have the power to require the
2 following information:

3 (A) certification by an independent actuary of the
4 adequacy of the reserves of the Health Maintenance
5 Organization sought to be acquired;

6 (B) pro forma financial statements reflecting the
7 combined balance sheets of the acquiring company and
8 the Health Maintenance Organization sought to be
9 acquired as of the end of the preceding year and as of
10 a date 90 days prior to the acquisition, as well as pro
11 forma financial statements reflecting projected
12 combined operation for a period of 2 years;

13 (C) a pro forma business plan detailing an
14 acquiring party's plans with respect to the operation
15 of the Health Maintenance Organization sought to be
16 acquired for a period of not less than 3 years; and

17 (D) such other information as the Director shall
18 require.

19 (d) The provisions of Article VIII 1/2 of the Illinois
20 Insurance Code and this Section 5-3 shall apply to the sale by
21 any health maintenance organization of greater than 10% of its
22 enrollee population (including without limitation the health
23 maintenance organization's right, title, and interest in and
24 to its health care certificates).

25 (e) In considering any management contract or service
26 agreement subject to Section 141.1 of the Illinois Insurance

1 Code, the Director (i) shall, in addition to the criteria
2 specified in Section 141.2 of the Illinois Insurance Code,
3 take into account the effect of the management contract or
4 service agreement on the continuation of benefits to enrollees
5 and the financial condition of the health maintenance
6 organization to be managed or serviced, and (ii) need not take
7 into account the effect of the management contract or service
8 agreement on competition.

9 (f) Except for small employer groups as defined in the
10 Small Employer Rating, Renewability and Portability Health
11 Insurance Act and except for medicare supplement policies as
12 defined in Section 363 of the Illinois Insurance Code, a
13 Health Maintenance Organization may by contract agree with a
14 group or other enrollment unit to effect refunds or charge
15 additional premiums under the following terms and conditions:

16 (i) the amount of, and other terms and conditions with
17 respect to, the refund or additional premium are set forth
18 in the group or enrollment unit contract agreed in advance
19 of the period for which a refund is to be paid or
20 additional premium is to be charged (which period shall
21 not be less than one year); and

22 (ii) the amount of the refund or additional premium
23 shall not exceed 20% of the Health Maintenance
24 Organization's profitable or unprofitable experience with
25 respect to the group or other enrollment unit for the
26 period (and, for purposes of a refund or additional

1 premium, the profitable or unprofitable experience shall
2 be calculated taking into account a pro rata share of the
3 Health Maintenance Organization's administrative and
4 marketing expenses, but shall not include any refund to be
5 made or additional premium to be paid pursuant to this
6 subsection (f)). The Health Maintenance Organization and
7 the group or enrollment unit may agree that the profitable
8 or unprofitable experience may be calculated taking into
9 account the refund period and the immediately preceding 2
10 plan years.

11 The Health Maintenance Organization shall include a
12 statement in the evidence of coverage issued to each enrollee
13 describing the possibility of a refund or additional premium,
14 and upon request of any group or enrollment unit, provide to
15 the group or enrollment unit a description of the method used
16 to calculate (1) the Health Maintenance Organization's
17 profitable experience with respect to the group or enrollment
18 unit and the resulting refund to the group or enrollment unit
19 or (2) the Health Maintenance Organization's unprofitable
20 experience with respect to the group or enrollment unit and
21 the resulting additional premium to be paid by the group or
22 enrollment unit.

23 In no event shall the Illinois Health Maintenance
24 Organization Guaranty Association be liable to pay any
25 contractual obligation of an insolvent organization to pay any
26 refund authorized under this Section.

1 (g) Rulemaking authority to implement Public Act 95-1045,
2 if any, is conditioned on the rules being adopted in
3 accordance with all provisions of the Illinois Administrative
4 Procedure Act and all rules and procedures of the Joint
5 Committee on Administrative Rules; any purported rule not so
6 adopted, for whatever reason, is unauthorized.

7 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
8 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff.
9 1-1-19; 100-1102, eff. 1-1-19; 101-13, eff. 6-12-19; 101-81,
10 eff. 7-12-19; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20;
11 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff.
12 1-1-20; 101-625, eff. 1-1-21.)

13 Section 45. The Voluntary Health Services Plans Act is
14 amended by changing Section 10 as follows:

15 (215 ILCS 165/10) (from Ch. 32, par. 604)

16 Sec. 10. Application of Insurance Code provisions. Health
17 services plan corporations and all persons interested therein
18 or dealing therewith shall be subject to the provisions of
19 Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140,
20 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b,
21 356g, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x,
22 356y, 356z.1, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8,
23 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15,
24 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29,

1 356z.30, 356z.30a, 356z.32, 356z.33, 356z.40, 356z.41, 364.01,
2 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412,
3 and paragraphs (7) and (15) of Section 367 of the Illinois
4 Insurance Code.

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

11 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
12 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff.
13 1-1-19; 100-1102, eff. 1-1-19; 101-13, eff. 6-12-19; 101-81,
14 eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20;
15 101-625, eff. 1-1-21.)

16 Section 50. The Illinois Public Aid Code is amended by
17 changing Sections 5-2, 5-5, and 5-5.24 and by adding Section
18 5-18.10 as follows:

19 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

20 Sec. 5-2. Classes of persons eligible. Medical assistance
21 under this Article shall be available to any of the following
22 classes of persons in respect to whom a plan for coverage has
23 been submitted to the Governor by the Illinois Department and
24 approved by him. If changes made in this Section 5-2 require

1 federal approval, they shall not take effect until such
2 approval has been received:

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

5 2. Beginning January 1, 2014, persons otherwise
6 eligible for basic maintenance under Article III,
7 excluding any eligibility requirements that are
8 inconsistent with any federal law or federal regulation,
9 as interpreted by the U.S. Department of Health and Human
10 Services, but who fail to qualify thereunder on the basis
11 of need, and who have insufficient income and resources to
12 meet the costs of necessary medical care, including, but
13 not limited to, the following:

14 (a) All persons otherwise eligible for basic
15 maintenance under Article III but who fail to qualify
16 under that Article on the basis of need and who meet
17 either of the following requirements:

18 (i) their income, as determined by the
19 Illinois Department in accordance with any federal
20 requirements, is equal to or less than 100% of the
21 federal poverty level; or

22 (ii) their income, after the deduction of
23 costs incurred for medical care and for other
24 types of remedial care, is equal to or less than
25 100% of the federal poverty level.

26 (b) (Blank).

1 3. (Blank).

2 4. Persons not eligible under any of the preceding
3 paragraphs who fall sick, are injured, or die, not having
4 sufficient money, property or other resources to meet the
5 costs of necessary medical care or funeral and burial
6 expenses.

7 5.(a) Beginning January 1, 2020, individuals ~~women~~
8 during pregnancy and during the 12-month period beginning
9 on the last day of the pregnancy, together with their
10 infants, whose income is at or below 200% of the federal
11 poverty level. Until September 30, 2019, or sooner if the
12 maintenance of effort requirements under the Patient
13 Protection and Affordable Care Act are eliminated or may
14 be waived before then, individuals ~~women~~ during pregnancy
15 and during the 12-month period beginning on the last day
16 of the pregnancy, whose countable monthly income, after
17 the deduction of costs incurred for medical care and for
18 other types of remedial care as specified in
19 administrative rule, is equal to or less than the Medical
20 Assistance-No Grant(C) (MANG(C)) Income Standard in effect
21 on April 1, 2013 as set forth in administrative rule.

22 (b) The plan for coverage shall provide ambulatory
23 prenatal care to pregnant individuals ~~women~~ during a
24 presumptive eligibility period and establish an income
25 eligibility standard that is equal to 200% of the federal
26 poverty level, provided that costs incurred for medical

1 care are not taken into account in determining such income
2 eligibility.

3 (c) The Illinois Department may conduct a
4 demonstration in at least one county that will provide
5 medical assistance to pregnant individuals ~~women~~, together
6 with their infants and children up to one year of age,
7 where the income eligibility standard is set up to 185% of
8 the nonfarm income official poverty line, as defined by
9 the federal Office of Management and Budget. The Illinois
10 Department shall seek and obtain necessary authorization
11 provided under federal law to implement such a
12 demonstration. Such demonstration may establish resource
13 standards that are not more restrictive than those
14 established under Article IV of this Code.

15 6. (a) Children younger than age 19 when countable
16 income is at or below 133% of the federal poverty level.
17 Until September 30, 2019, or sooner if the maintenance of
18 effort requirements under the Patient Protection and
19 Affordable Care Act are eliminated or may be waived before
20 then, children younger than age 19 whose countable monthly
21 income, after the deduction of costs incurred for medical
22 care and for other types of remedial care as specified in
23 administrative rule, is equal to or less than the Medical
24 Assistance-No Grant (C) (MANG(C)) Income Standard in effect
25 on April 1, 2013 as set forth in administrative rule.

26 (b) Children and youth who are under temporary custody

1 or guardianship of the Department of Children and Family
2 Services or who receive financial assistance in support of
3 an adoption or guardianship placement from the Department
4 of Children and Family Services.

5 7. (Blank).

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

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

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

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

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

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

23 (iv) such coverage shall be suspended in the
24 event of a person's failure without good cause to
25 file in a timely fashion reports required for this
26 coverage under the Social Security Act and

1 coverage shall be reinstated upon the filing of
2 such reports if the person remains otherwise
3 eligible.

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

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

19 11. Persons with disabilities who are employed and
20 eligible for Medicaid, pursuant to Section
21 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,
22 subject to federal approval, persons with a medically
23 improved disability who are employed and eligible for
24 Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of
25 the Social Security Act, as provided by the Illinois
26 Department by rule. In establishing eligibility standards

1 under this paragraph 11, the Department shall, subject to
2 federal approval:

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

5 (b) exempt retirement accounts that the person
6 cannot access without penalty before the age of 59
7 1/2, and medical savings accounts established pursuant
8 to 26 U.S.C. 220;

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

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

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

22 (1) persons who have been screened for breast or
23 cervical cancer under the U.S. Centers for Disease
24 Control and Prevention Breast and Cervical Cancer
25 Program established under Title XV of the federal
26 Public Health Service ~~Services~~ Act in accordance with

1 the requirements of Section 1504 of that Act as
2 administered by the Illinois Department of Public
3 Health; and

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

8 "Medical assistance" under this paragraph 12 shall be
9 identical to the benefits provided under the State's
10 approved plan under Title XIX of the Social Security Act.
11 The Department must request federal approval of the
12 coverage under this paragraph 12 within 30 days after July
13 3, 2001 (the effective date of Public Act 92-47) ~~this~~
14 ~~amendatory Act of the 92nd General Assembly.~~

15 In addition to the persons who are eligible for
16 medical assistance pursuant to subparagraphs (1) and (2)
17 of this paragraph 12, and to be paid from funds
18 appropriated to the Department for its medical programs,
19 any uninsured person as defined by the Department in rules
20 residing in Illinois who is younger than 65 years of age,
21 who has been screened for breast and cervical cancer in
22 accordance with standards and procedures adopted by the
23 Department of Public Health for screening, and who is
24 referred to the Department by the Department of Public
25 Health as being in need of treatment for breast or
26 cervical cancer is eligible for medical assistance

1 benefits that are consistent with the benefits provided to
2 those persons described in subparagraphs (1) and (2).
3 Medical assistance coverage for the persons who are
4 eligible under the preceding sentence is not dependent on
5 federal approval, but federal moneys may be used to pay
6 for services provided under that coverage upon federal
7 approval.

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

13 14. Subject to the availability of funds for this
14 purpose, the Department may provide coverage under this
15 Article to persons who reside in Illinois who are not
16 eligible under any of the preceding paragraphs and who
17 meet the income guidelines of paragraph 2(a) of this
18 Section and (i) have an application for asylum pending
19 before the federal Department of Homeland Security or on
20 appeal before a court of competent jurisdiction and are
21 represented either by counsel or by an advocate accredited
22 by the federal Department of Homeland Security and
23 employed by a not-for-profit organization in regard to
24 that application or appeal, or (ii) are receiving services
25 through a federally funded torture treatment center.
26 Medical coverage under this paragraph 14 may be provided

1 for up to 24 continuous months from the initial
2 eligibility date so long as an individual continues to
3 satisfy the criteria of this paragraph 14. If an
4 individual has an appeal pending regarding an application
5 for asylum before the Department of Homeland Security,
6 eligibility under this paragraph 14 may be extended until
7 a final decision is rendered on the appeal. The Department
8 may adopt rules governing the implementation of this
9 paragraph 14.

10 15. Family Care Eligibility.

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

16 (b) Eligibility shall be reviewed annually.

17 (c) (Blank).

18 (d) (Blank).

19 (e) (Blank).

20 (f) (Blank).

21 (g) (Blank).

22 (h) (Blank).

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

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

1 treatment. "Medical assistance" under this paragraph 16
2 shall be identical to the benefits provided under the
3 State's approved plan under Title XIX of the Social
4 Security Act. Notwithstanding any other provision of law,
5 the Department (i) does not have a claim against the
6 estate of a deceased recipient of services under this
7 paragraph 16 and (ii) does not have a lien against any
8 homestead property or other legal or equitable real
9 property interest owned by a recipient of services under
10 this paragraph 16.

11 17. Persons who, pursuant to a waiver approved by the
12 Secretary of the U.S. Department of Health and Human
13 Services, are eligible for medical assistance under Title
14 XIX or XXI of the federal Social Security Act.
15 Notwithstanding any other provision of this Code and
16 consistent with the terms of the approved waiver, the
17 Illinois Department, may by rule:

18 (a) Limit the geographic areas in which the waiver
19 program operates.

20 (b) Determine the scope, quantity, duration, and
21 quality, and the rate and method of reimbursement, of
22 the medical services to be provided, which may differ
23 from those for other classes of persons eligible for
24 assistance under this Article.

25 (c) Restrict the persons' freedom in choice of
26 providers.

1 18. Beginning January 1, 2014, persons aged 19 or
2 older, but younger than 65, who are not otherwise eligible
3 for medical assistance under this Section 5-2, who qualify
4 for medical assistance pursuant to 42 U.S.C.
5 1396a(a)(10)(A)(i)(VIII) and applicable federal
6 regulations, and who have income at or below 133% of the
7 federal poverty level plus 5% for the applicable family
8 size as determined pursuant to 42 U.S.C. 1396a(e)(14) and
9 applicable federal regulations. Persons eligible for
10 medical assistance under this paragraph 18 shall receive
11 coverage for the Health Benefits Service Package as that
12 term is defined in subsection (m) of Section 5-1.1 of this
13 Code. If Illinois' federal medical assistance percentage
14 (FMAP) is reduced below 90% for persons eligible for
15 medical assistance under this paragraph 18, eligibility
16 under this paragraph 18 shall cease no later than the end
17 of the third month following the month in which the
18 reduction in FMAP takes effect.

19 19. Beginning January 1, 2014, as required under 42
20 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18
21 and younger than age 26 who are not otherwise eligible for
22 medical assistance under paragraphs (1) through (17) of
23 this Section who (i) were in foster care under the
24 responsibility of the State on the date of attaining age
25 18 or on the date of attaining age 21 when a court has
26 continued wardship for good cause as provided in Section

1 2-31 of the Juvenile Court Act of 1987 and (ii) received
2 medical assistance under the Illinois Title XIX State Plan
3 or waiver of such plan while in foster care.

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

25 21. Persons who are not otherwise eligible for medical
26 assistance under this Section who may qualify for medical

1 assistance pursuant to 42 U.S.C.
2 1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the
3 duration of any federal or State declared emergency due to
4 COVID-19. Medical assistance to persons eligible for
5 medical assistance solely pursuant to this paragraph 21
6 shall be limited to any in vitro diagnostic product (and
7 the administration of such product) described in 42 U.S.C.
8 1396d(a)(3)(B) on or after March 18, 2020, any visit
9 described in 42 U.S.C. 1396o(a)(2)(G), or any other
10 medical assistance that may be federally authorized for
11 this class of persons. The Department may also cover
12 treatment of COVID-19 for this class of persons, or any
13 similar category of uninsured individuals, to the extent
14 authorized under a federally approved 1115 Waiver or other
15 federal authority. Notwithstanding the provisions of
16 Section 1-11 of this Code, due to the nature of the
17 COVID-19 public health emergency, the Department may cover
18 and provide the medical assistance described in this
19 paragraph 21 to noncitizens who would otherwise meet the
20 eligibility requirements for the class of persons
21 described in this paragraph 21 for the duration of the
22 State emergency period.

23 In implementing the provisions of Public Act 96-20, the
24 Department is authorized to adopt only those rules necessary,
25 including emergency rules. Nothing in Public Act 96-20 permits
26 the Department to adopt rules or issue a decision that expands

1 eligibility for the FamilyCare Program to a person whose
2 income exceeds 185% of the Federal Poverty Level as determined
3 from time to time by the U.S. Department of Health and Human
4 Services, unless the Department is provided with express
5 statutory authority.

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

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

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

24 The eligibility of any person for medical assistance under
25 this Article shall not be affected by the receipt by the person
26 of donations or benefits from fundraisers held for the person

1 in cases of serious illness, as long as neither the person nor
2 members of the person's family have actual control over the
3 donations or benefits or the disbursement of the donations or
4 benefits.

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

18 Notwithstanding any other provision of this Code, if an
19 Act of Congress that becomes a Public Law eliminates Section
20 2001(a) of Public Law 111-148, the State or a unit of local
21 government shall be prohibited from enrolling individuals in
22 the Medical Assistance Program as the result of federal
23 approval of a State Medicaid waiver on or after June 14, 2012
24 (the effective date of Public Act 97-687) ~~this amendatory Act~~
25 ~~of the 97th General Assembly~~, and any individuals enrolled in
26 the Medical Assistance Program pursuant to eligibility

1 permitted as a result of such a State Medicaid waiver shall
2 become immediately ineligible.

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

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

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

17 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

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

1 tool, or process that all must utilize; (14) transportation
2 and such other expenses as may be necessary; (15) medical
3 treatment of sexual assault survivors, as defined in Section
4 1a of the Sexual Assault Survivors Emergency Treatment Act,
5 for injuries sustained as a result of the sexual assault,
6 including examinations and laboratory tests to discover
7 evidence which may be used in criminal proceedings arising
8 from the sexual assault; (16) the diagnosis and treatment of
9 sickle cell anemia; and (17) any other medical care, and any
10 other type of remedial care recognized under the laws of this
11 State. The term "any other type of remedial care" shall
12 include nursing care and nursing home service for persons who
13 rely on treatment by spiritual means alone through prayer for
14 healing.

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

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

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

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

26 On and after July 1, 2012, the Department of Healthcare

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

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

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

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

22 On and after July 1, 2018, targeted dental services, as
23 set forth in Exhibit D of the Consent Decree entered by the
24 United States District Court for the Northern District of
25 Illinois, Eastern Division, in the matter of Memisovski v.
26 Maram, Case No. 92 C 1982, that are provided to adults under

1 the medical assistance program shall be established at no less
2 than the rates set forth in the "New Rate" column in Exhibit D
3 of the Consent Decree for targeted dental services that are
4 provided to persons under the age of 18 under the medical
5 assistance program.

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

19 The Illinois Department, by rule, may distinguish and
20 classify the medical services to be provided only in
21 accordance with the classes of persons designated in Section
22 5-2.

23 The Department of Healthcare and Family Services must
24 provide coverage and reimbursement for amino acid-based
25 elemental formulas, regardless of delivery method, for the
26 diagnosis and treatment of (i) eosinophilic disorders and (ii)

1 short bowel syndrome when the prescribing physician has issued
2 a written order stating that the amino acid-based elemental
3 formula is medically necessary.

4 The Illinois Department shall authorize the provision of,
5 and shall authorize payment for, screening by low-dose
6 mammography for the presence of occult breast cancer for
7 individuals ~~women~~ 35 years of age or older who are eligible for
8 medical assistance under this Article, as follows:

9 (A) A baseline mammogram for individuals ~~women~~ 35 to
10 39 years of age.

11 (B) An annual mammogram for individuals ~~women~~ 40 years
12 of age or older.

13 (C) A mammogram at the age and intervals considered
14 medically necessary by the individual's ~~woman's~~ health
15 care provider for individuals ~~women~~ under 40 years of age
16 and having a family history of breast cancer, prior
17 personal history of breast cancer, positive genetic
18 testing, or other risk factors.

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

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

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

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

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

17 For purposes of this Section:

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

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

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

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

6 "Breast tomosynthesis" means a radiologic procedure that
7 involves the acquisition of projection images over the
8 stationary breast to produce cross-sectional digital
9 three-dimensional images of the breast.

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

26 On and after January 1, 2016, the Department shall ensure

1 that all networks of care for adult clients of the Department
2 include access to at least one breast imaging Center of
3 Imaging Excellence as certified by the American College of
4 Radiology.

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

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

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

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

26 Subject to federal approval, the Department shall

1 establish a rate methodology for mammography at federally
2 qualified health centers and other encounter-rate clinics.
3 These clinics or centers may also collaborate with other
4 hospital-based mammography facilities. By January 1, 2016, the
5 Department shall report to the General Assembly on the status
6 of the provision set forth in this paragraph.

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

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

22 The Department shall devise a means of case-managing or
23 patient navigation for beneficiaries diagnosed with breast
24 cancer. This program shall initially operate as a pilot
25 program in areas of the State with the highest incidence of
26 mortality related to breast cancer. At least one pilot program

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

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

18 On or after July 1, 2022, individuals who are otherwise
19 eligible for medical assistance under this Article shall
20 receive coverage for perinatal depression screenings for the
21 12-month period beginning on the last day of their pregnancy.
22 Medical assistance coverage under this paragraph shall be
23 conditioned on the use of a screening instrument approved by
24 the Department.

25 Any medical or health care provider shall immediately
26 recommend, to any pregnant individual ~~woman~~ who is being

1 provided prenatal services and is suspected of having a
2 substance use disorder as defined in the Substance Use
3 Disorder Act, referral to a local substance use disorder
4 treatment program licensed by the Department of Human Services
5 or to a licensed hospital which provides substance abuse
6 treatment services. The Department of Healthcare and Family
7 Services shall assure coverage for the cost of treatment of
8 the drug abuse or addiction for pregnant recipients in
9 accordance with the Illinois Medicaid Program in conjunction
10 with the Department of Human Services.

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

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

1 Neither the Department of Healthcare and Family Services
2 nor the Department of Human Services shall sanction the
3 recipient solely on the basis of the recipient's ~~her~~ substance
4 abuse.

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

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

24 The sponsor must negotiate formal written contracts with
25 medical providers for physician services, inpatient and
26 outpatient hospital care, home health services, treatment for

1 alcoholism and substance abuse, and other services determined
2 necessary by the Illinois Department by rule for delivery by
3 Partnerships. Physician services must include prenatal and
4 obstetrical care. The Illinois Department shall reimburse
5 medical services delivered by Partnership providers to clients
6 in target areas according to provisions of this Article and
7 the Illinois Health Finance Reform Act, except that:

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

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

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

20 Medical providers shall be required to meet certain
21 qualifications to participate in Partnerships to ensure the
22 delivery of high quality medical services. These
23 qualifications shall be determined by rule of the Illinois
24 Department and may be higher than qualifications for
25 participation in the medical assistance program. Partnership
26 sponsors may prescribe reasonable additional qualifications

1 for participation by medical providers, only with the prior
2 written approval of the Illinois Department.

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

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

15 The Illinois Department shall require health care
16 providers to maintain records that document the medical care
17 and services provided to recipients of Medical Assistance
18 under this Article. Such records must be retained for a period
19 of not less than 6 years from the date of service or as
20 provided by applicable State law, whichever period is longer,
21 except that if an audit is initiated within the required
22 retention period then the records must be retained until the
23 audit is completed and every exception is resolved. The
24 Illinois Department shall require health care providers to
25 make available, when authorized by the patient, in writing,
26 the medical records in a timely fashion to other health care

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

1 the acquisition costs of all prescription drugs shall be
2 updated no less frequently than every 30 days as required by
3 Section 5-5.12.

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

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

26 The Illinois Department shall require all dispensers of

1 medical services, other than an individual practitioner or
2 group of practitioners, desiring to participate in the Medical
3 Assistance program established under this Article to disclose
4 all financial, beneficial, ownership, equity, surety or other
5 interests in any and all firms, corporations, partnerships,
6 associations, business enterprises, joint ventures, agencies,
7 institutions or other legal entities providing any form of
8 health care services in this State under this Article.

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

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

26 The Department has the discretion to limit the conditional

1 enrollment period for vendors based upon category of risk of
2 the vendor.

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

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

25 To be eligible for payment consideration, a vendor's
26 payment claim or bill, either as an initial claim or as a

1 resubmitted claim following prior rejection, must be received
2 by the Illinois Department, or its fiscal intermediary, no
3 later than 180 days after the latest date on the claim on which
4 medical goods or services were provided, with the following
5 exceptions:

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

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

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

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

22 For claims for services rendered during a period for which
23 a recipient received retroactive eligibility, claims must be
24 filed within 180 days after the Department determines the
25 applicant is eligible. For claims for which the Illinois
26 Department is not the primary payer, claims must be submitted

1 to the Illinois Department within 180 days after the final
2 adjudication by the primary payer.

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

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

22 To the extent consistent with applicable information and
23 privacy, security, and disclosure laws, State and federal
24 agencies and departments shall provide the Illinois Department
25 access to confidential and other information and data
26 necessary to perform eligibility and payment verifications and

1 other Illinois Department functions. This includes, but is not
2 limited to: information pertaining to licensure;
3 certification; earnings; immigration status; citizenship; wage
4 reporting; unearned and earned income; pension income;
5 employment; supplemental security income; social security
6 numbers; National Provider Identifier (NPI) numbers; the
7 National Practitioner Data Bank (NPDB); program and agency
8 exclusions; taxpayer identification numbers; tax delinquency;
9 corporate information; and death records.

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

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

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

1 alternative or substitute devices or equipment pending repairs
2 or replacements of any device or equipment previously
3 authorized for such recipient by the Department.
4 Notwithstanding any provision of Section 5-5f to the contrary,
5 the Department may, by rule, exempt certain replacement
6 wheelchair parts from prior approval and, for wheelchairs,
7 wheelchair parts, wheelchair accessories, and related seating
8 and positioning items, determine the wholesale price by
9 methods other than actual acquisition costs.

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

18 In order to promote environmental responsibility, meet the
19 needs of recipients and enrollees, and achieve significant
20 cost savings, the Department, or a managed care organization
21 under contract with the Department, may provide recipients or
22 managed care enrollees who have a prescription or Certificate
23 of Medical Necessity access to refurbished durable medical
24 equipment under this Section (excluding prosthetic and
25 orthotic devices as defined in the Orthotics, Prosthetics, and
26 Pedorthics Practice Act and complex rehabilitation technology

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

21 The Department shall execute, relative to the nursing home
22 prescreening project, written inter-agency agreements with the
23 Department of Human Services and the Department on Aging, to
24 effect the following: (i) intake procedures and common
25 eligibility criteria for those persons who are receiving
26 non-institutional services; and (ii) the establishment and

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

26 The Illinois Department shall develop and operate, in

1 cooperation with other State Departments and agencies and in
2 compliance with applicable federal laws and regulations,
3 appropriate and effective systems of health care evaluation
4 and programs for monitoring of utilization of health care
5 services and facilities, as it affects persons eligible for
6 medical assistance under this Code.

7 The Illinois Department shall report annually to the
8 General Assembly, no later than the second Friday in April of
9 1979 and each year thereafter, in regard to:

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

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

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

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

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

1 Library Act.

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

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

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

1 and the services under this Section shall be limited to
2 services associated with kidney transplantation.

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

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

26 Upon federal approval, the Department shall provide

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

12 A federally qualified health center, as defined in Section
13 1905(1)(2)(B) of the federal Social Security Act, shall be
14 reimbursed by the Department in accordance with the federally
15 qualified health center's encounter rate for services provided
16 to medical assistance recipients that are performed by a
17 dental hygienist, as defined under the Illinois Dental
18 Practice Act, working under the general supervision of a
19 dentist and employed by a federally qualified health center.

20 Within 90 days after the effective date of this amendatory
21 Act of the 102nd General Assembly, the Department shall seek
22 federal approval of a State Plan amendment to expand coverage
23 for family planning services that includes presumptive
24 eligibility to individuals whose income is at or below 208% of
25 the federal poverty level. Coverage under this Section shall
26 be effective beginning on July 1, 2022.

1 (Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18;
2 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff.
3 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974,
4 eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19;
5 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff.
6 1-1-20; revised 9-18-19.)

7 (305 ILCS 5/5-5.24)

8 Sec. 5-5.24. Prenatal and perinatal care. The Department
9 of Healthcare and Family Services may provide reimbursement
10 under this Article for all prenatal and perinatal health care
11 services that are provided for the purpose of preventing
12 low-birthweight infants, reducing the need for neonatal
13 intensive care hospital services, and promoting perinatal and
14 maternal health. These services may include comprehensive risk
15 assessments for pregnant individuals ~~women~~, individuals ~~women~~
16 with infants, and infants, lactation counseling, nutrition
17 counseling, childbirth support, psychosocial counseling,
18 treatment and prevention of periodontal disease, language
19 translation, nurse home visitation, and other support services
20 that have been proven to improve birth and maternal health
21 outcomes. The Department shall maximize the use of preventive
22 prenatal and perinatal health care services consistent with
23 federal statutes, rules, and regulations. The Department of
24 Public Aid (now Department of Healthcare and Family Services)
25 shall develop a plan for prenatal and perinatal preventive

1 health care and shall present the plan to the General Assembly
2 by January 1, 2004. On or before January 1, 2006 and every 2
3 years thereafter, the Department shall report to the General
4 Assembly concerning the effectiveness of prenatal and
5 perinatal health care services reimbursed under this Section
6 in preventing low-birthweight infants and reducing the need
7 for neonatal intensive care hospital services. Each such
8 report shall include an evaluation of how the ratio of
9 expenditures for treating low-birthweight infants compared
10 with the investment in promoting healthy births and infants in
11 local community areas throughout Illinois relates to healthy
12 infant development in those areas.

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

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

19 (305 ILCS 5/5-18.10 new)

20 Sec. 5-18.10. Reimbursement for postpartum visits.

21 (a) In this Section:

22 "Certified lactation counselor" means a health care
23 professional in lactation counseling who has demonstrated the
24 necessary skills, knowledge, and attitudes to provide clinical
25 breastfeeding counseling and management support to families

1 who are thinking about breastfeeding or who have questions or
2 problems during the course of breastfeeding.

3 "Certified nurse midwife" means a person who exceeds the
4 competencies for a midwife contained in the Essential
5 Competencies for Midwifery Practice, published by the
6 International Confederation of Midwives, and who qualifies as
7 an advanced practice registered nurse.

8 "Community health worker" means a frontline public health
9 worker who is a trusted member or has an unusually close
10 understanding of the community served. This trusting
11 relationship enables the community health worker to serve as a
12 liaison, link, and intermediary between health and social
13 services and the community to facilitate access to services
14 and improve the quality and cultural competence of service
15 delivery.

16 "International board-certified lactation consultant"
17 means a health care professional who is certified by the
18 International Board of Lactation Consultant Examiners and
19 specializes in the clinical management of breastfeeding.

20 "Medical caseworker" means a health care professional who
21 assists in the planning, coordination, monitoring, and
22 evaluation of medical services for a patient with emphasis on
23 quality of care, continuity of services, and affordability.

24 "Perinatal doula" means a trained provider of regular and
25 voluntary physical, emotional, and educational support, but
26 not medical or midwife care, to pregnant and birthing persons

1 before, during, and after childbirth, otherwise known as the
2 perinatal period.

3 "Public health nurse" means a registered nurse who
4 promotes and protects the health of populations using
5 knowledge from nursing, social, and public health sciences.

6 (b) The Illinois Department shall establish a medical
7 assistance program to cover a universal postpartum visit
8 within the first 3 weeks after childbirth and a comprehensive
9 visit within 4 to 12 weeks postpartum for persons who are
10 otherwise eligible for medical assistance under this Article.
11 In addition, postpartum care services rendered by perinatal
12 doulas, certified lactation counselors, international
13 board-certified lactation consultants, public health nurses,
14 certified nurse midwives, community health workers, and
15 medical caseworkers shall be covered under the medical
16 assistance program.

17 Section 99. Effective date. This Act takes effect upon
18 becoming law.