



Rep. Robyn Gabel

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1 AMENDMENT TO SENATE BILL 3682

2 AMENDMENT NO. _____. Amend Senate Bill 3682 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. Short title. This Act may be cited as the
5 Reducing Cervical Cancer and Saving Lives Act.

6 Section 5. Applicability. This Act applies to a facility
7 that provides cervical cancer screening services in the State
8 of Illinois.

9 Section 10. Definitions. As used in this Act:

10 "Cervical cancer screening service" means an examination
11 and laboratory test for the screening and detection of
12 cervical cancer, including conventional Pap smear screening,
13 liquid-based cytology, or human papillomavirus (HPV) detection
14 methods.

15 "Department" means the Department of Public Health.

1 "Facility" means a hospital, outpatient department,
2 clinic, mobile unit, or physician's office that conducts
3 cervical cancer screening services.

4 Section 15. Cervical cancer screening services; written
5 report.

6 (a) A facility shall prepare a written report of the
7 results of any cervical cancer screening service provided to a
8 patient. The written report shall be signed by the
9 interpreting physician. The written report shall be provided
10 to the patient's physician, if any. If a patient's physician
11 is not available or if there is no such physician, only the
12 written report under subsection (b) is required.

13 (b) A summary of the written report of the results of any
14 cervical cancer screening service signed by the interpreting
15 physician shall be sent directly to the patient in terms
16 easily understood by a lay person.

17 (c) The Department shall develop suggested cervical cancer
18 screening reporting language, in terms easily understood by a
19 lay person, to be sent to patients under subsection (b).

20 (d) This Section does not create a duty of care or other
21 legal obligation beyond the duty to provide a written report
22 as set forth in this Section.

23 Section 20. Human papillomavirus (HPV) vaccine services.

24 (a) The Department shall provide for the administration of

1 human papillomavirus (HPV) vaccines that are approved for
2 marketing by the Food and Drug Administration for persons who:

3 (1) are either (i) aged 45 and under; or (ii) aged 46
4 and above and have been diagnosed with cervical dysplasia
5 with a high risk of recurrence or progression; and

6 (2) are either (i) eligible to be screened for breast
7 or cervical cancer under the Centers for Disease Control
8 and Prevention's National Breast and Cervical Cancer Early
9 Detection Program established under the Breast and
10 Cervical Cancer Mortality Prevention Act of 1990 in
11 accordance with the requirements of Section 300n of that
12 Act as administered by the Department; or (ii) are
13 eligible to be screened under that program and funded in
14 whole or in part by funds appropriated to the Department
15 for breast or cervical cancer screening.

16 (b) The Department shall disallow any preauthorization
17 requirements for the administration of the human
18 papillomavirus (HPV) vaccine referred to in subsection (a).

19 Section 50. The Illinois Public Aid Code is amended by
20 changing Section 5-5 as follows:

21 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

22 Sec. 5-5. Medical services. The Illinois Department, by
23 rule, shall determine the quantity and quality of and the rate
24 of reimbursement for the medical assistance for which payment

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

1 adults; for purposes of this item (13), a uniform screening,
2 assessment, and evaluation process refers to a process that
3 includes an appropriate evaluation and, as warranted, a
4 referral; "uniform" does not mean the use of a singular
5 instrument, tool, or process that all must utilize; (14)
6 transportation and such other expenses as may be necessary;
7 (15) medical treatment of sexual assault survivors, as defined
8 in Section 1a of the Sexual Assault Survivors Emergency
9 Treatment Act, for injuries sustained as a result of the
10 sexual assault, including examinations and laboratory tests to
11 discover evidence which may be used in criminal proceedings
12 arising from the sexual assault; (16) the diagnosis and
13 treatment of sickle cell anemia; (16.5) services performed by
14 a chiropractic physician licensed under the Medical Practice
15 Act of 1987 and acting within the scope of his or her license,
16 including, but not limited to, chiropractic manipulative
17 treatment; and (17) any other medical care, and any other type
18 of remedial care recognized under the laws of this State. The
19 term "any other type of remedial care" shall include nursing
20 care and nursing home service for persons who rely on
21 treatment by spiritual means alone through prayer for healing.

22 Notwithstanding any other provision of this Section, a
23 comprehensive tobacco use cessation program that includes
24 purchasing prescription drugs or prescription medical devices
25 approved by the Food and Drug Administration shall be covered
26 under the medical assistance program under this Article for

1 persons who are otherwise eligible for assistance under this
2 Article.

3 Notwithstanding any other provision of this Code,
4 reproductive health care that is otherwise legal in Illinois
5 shall be covered under the medical assistance program for
6 persons who are otherwise eligible for medical assistance
7 under this Article.

8 Notwithstanding any other provision of this Section, all
9 tobacco cessation medications approved by the United States
10 Food and Drug Administration and all individual and group
11 tobacco cessation counseling services and telephone-based
12 counseling services and tobacco cessation medications provided
13 through the Illinois Tobacco Quitline shall be covered under
14 the medical assistance program for persons who are otherwise
15 eligible for assistance under this Article. The Department
16 shall comply with all federal requirements necessary to obtain
17 federal financial participation, as specified in 42 CFR
18 433.15(b)(7), for telephone-based counseling services provided
19 through the Illinois Tobacco Quitline, including, but not
20 limited to: (i) entering into a memorandum of understanding or
21 interagency agreement with the Department of Public Health, as
22 administrator of the Illinois Tobacco Quitline; and (ii)
23 developing a cost allocation plan for Medicaid-allowable
24 Illinois Tobacco Quitline services in accordance with 45 CFR
25 95.507. The Department shall submit the memorandum of
26 understanding or interagency agreement, the cost allocation

1 plan, and all other necessary documentation to the Centers for
2 Medicare and Medicaid Services for review and approval.
3 Coverage under this paragraph shall be contingent upon federal
4 approval.

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

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

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

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

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

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

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

26 On and after July 1, 2018, targeted dental services, as

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

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

23 On and after January 1, 2022, the Department of Healthcare
24 and Family Services shall administer and regulate a
25 school-based dental program that allows for the out-of-office
26 delivery of preventative dental services in a school setting

1 to children under 19 years of age. The Department shall
2 establish, by rule, guidelines for participation by providers
3 and set requirements for follow-up referral care based on the
4 requirements established in the Dental Office Reference Manual
5 published by the Department that establishes the requirements
6 for dentists participating in the All Kids Dental School
7 Program. Every effort shall be made by the Department when
8 developing the program requirements to consider the different
9 geographic differences of both urban and rural areas of the
10 State for initial treatment and necessary follow-up care. No
11 provider shall be charged a fee by any unit of local government
12 to participate in the school-based dental program administered
13 by the Department. Nothing in this paragraph shall be
14 construed to limit or preempt a home rule unit's or school
15 district's authority to establish, change, or administer a
16 school-based dental program in addition to, or independent of,
17 the school-based dental program administered by the
18 Department.

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 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 35 to 39
10 years of age.

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

13 (C) A mammogram at the age and intervals considered
14 medically necessary by the individual's health care
15 provider for individuals under 40 years of age and having
16 a family history of breast cancer, prior personal history
17 of breast cancer, positive genetic testing, or other risk
18 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 and, after the
10 effective date of this amendatory Act of the 102nd General
11 Assembly, breast tomosynthesis.

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

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

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

1 quality standards for breast cancer treatment.

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

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

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

24 The Department shall devise a means of case-managing or
25 patient navigation for beneficiaries diagnosed with breast
26 cancer. This program shall initially operate as a pilot

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

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

20 The Department shall provide coverage and reimbursement
21 for a human papillomavirus (HPV) vaccine that is approved for
22 marketing by the federal Food and Drug Administration for all
23 persons between the ages of 9 and 45 and persons of the age of
24 46 and above who have been diagnosed with cervical dysplasia
25 with a high risk of recurrence or progression. The Department
26 shall disallow any preauthorization requirements for the

1 administration of the human papillomavirus (HPV) vaccine.

2 On or after July 1, 2022, individuals who are otherwise
3 eligible for medical assistance under this Article shall
4 receive coverage for perinatal depression screenings for the
5 12-month period beginning on the last day of their pregnancy.
6 Medical assistance coverage under this paragraph shall be
7 conditioned on the use of a screening instrument approved by
8 the Department.

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

21 All medical providers providing medical assistance to
22 pregnant individuals under this Code shall receive information
23 from the Department on the availability of services under any
24 program providing case management services for addicted
25 individuals, including information on appropriate referrals
26 for other social services that may be needed by addicted

1 individuals in addition to treatment for addiction.

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

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

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

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

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

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

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

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

25 (3) Persons receiving medical services through
26 Partnerships may receive medical and case management

1 services above the level usually offered through the
2 medical assistance program.

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

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

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

24 The Illinois Department shall require health care
25 providers to maintain records that document the medical care
26 and services provided to recipients of Medical Assistance

1 under this Article. Such records must be retained for a period
2 of not less than 6 years from the date of service or as
3 provided by applicable State law, whichever period is longer,
4 except that if an audit is initiated within the required
5 retention period then the records must be retained until the
6 audit is completed and every exception is resolved. The
7 Illinois Department shall require health care providers to
8 make available, when authorized by the patient, in writing,
9 the medical records in a timely fashion to other health care
10 providers who are treating or serving persons eligible for
11 Medical Assistance under this Article. All dispensers of
12 medical services shall be required to maintain and retain
13 business and professional records sufficient to fully and
14 accurately document the nature, scope, details and receipt of
15 the health care provided to persons eligible for medical
16 assistance under this Code, in accordance with regulations
17 promulgated by the Illinois Department. The rules and
18 regulations shall require that proof of the receipt of
19 prescription drugs, dentures, prosthetic devices and
20 eyeglasses by eligible persons under this Section accompany
21 each claim for reimbursement submitted by the dispenser of
22 such medical services. No such claims for reimbursement shall
23 be approved for payment by the Illinois Department without
24 such proof of receipt, unless the Illinois Department shall
25 have put into effect and shall be operating a system of
26 post-payment audit and review which shall, on a sampling

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

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

24 Notwithstanding any other law to the contrary, the
25 Illinois Department shall, within 365 days after August 15,
26 2014 (the effective date of Public Act 98-963), establish

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

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

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

26 Enrollment of a vendor shall be subject to a provisional

1 period and shall be conditional for one year. During the
2 period of conditional enrollment, the Department may terminate
3 the vendor's eligibility to participate in, or may disenroll
4 the vendor from, the medical assistance program without cause.
5 Unless otherwise specified, such termination of eligibility or
6 disenrollment is not subject to the Department's hearing
7 process. However, a disenrolled vendor may reapply without
8 penalty.

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

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

24 The Department shall define or specify the following: (i)
25 by provider notice, the "category of risk of the vendor" for
26 each type of vendor, which shall take into account the level of

1 screening applicable to a particular category of vendor under
2 federal law and regulations; (ii) by rule or provider notice,
3 the maximum length of the conditional enrollment period for
4 each category of risk of the vendor; and (iii) by rule, the
5 hearing rights, if any, afforded to a vendor in each category
6 of risk of the vendor that is terminated or disenrolled during
7 the conditional enrollment period.

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

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

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

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

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

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

12 In the case of long term care facilities, within 120
13 calendar days of receipt by the facility of required
14 prescreening information, new admissions with associated
15 admission documents shall be submitted through the Medical
16 Electronic Data Interchange (MEDI) or the Recipient
17 Eligibility Verification (REV) System or shall be submitted
18 directly to the Department of Human Services using required
19 admission forms. Effective September 1, 2014, admission
20 documents, including all prescreening information, must be
21 submitted through MEDI or REV. Confirmation numbers assigned
22 to an accepted transaction shall be retained by a facility to
23 verify timely submittal. Once an admission transaction has
24 been completed, all resubmitted claims following prior
25 rejection are subject to receipt no later than 180 days after
26 the admission transaction has been completed.

1 Claims that are not submitted and received in compliance
2 with the foregoing requirements shall not be eligible for
3 payment under the medical assistance program, and the State
4 shall have no liability for payment of those claims.

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

19 The Illinois Department shall enter into agreements with
20 State agencies and departments, and is authorized to enter
21 into agreements with federal agencies and departments, under
22 which such agencies and departments shall share data necessary
23 for medical assistance program integrity functions and
24 oversight. The Illinois Department shall develop, in
25 cooperation with other State departments and agencies, and in
26 compliance with applicable federal laws and regulations,

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

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

24 The Illinois Department shall establish policies,
25 procedures, standards and criteria by rule for the
26 acquisition, repair and replacement of orthotic and prosthetic

1 devices and durable medical equipment. Such rules shall
2 provide, but not be limited to, the following services: (1)
3 immediate repair or replacement of such devices by recipients;
4 and (2) rental, lease, purchase or lease-purchase of durable
5 medical equipment in a cost-effective manner, taking into
6 consideration the recipient's medical prognosis, the extent of
7 the recipient's needs, and the requirements and costs for
8 maintaining such equipment. Subject to prior approval, such
9 rules shall enable a recipient to temporarily acquire and use
10 alternative or substitute devices or equipment pending repairs
11 or replacements of any device or equipment previously
12 authorized for such recipient by the Department.
13 Notwithstanding any provision of Section 5-5f to the contrary,
14 the Department may, by rule, exempt certain replacement
15 wheelchair parts from prior approval and, for wheelchairs,
16 wheelchair parts, wheelchair accessories, and related seating
17 and positioning items, determine the wholesale price by
18 methods other than actual acquisition costs.

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

1 In order to promote environmental responsibility, meet the
2 needs of recipients and enrollees, and achieve significant
3 cost savings, the Department, or a managed care organization
4 under contract with the Department, may provide recipients or
5 managed care enrollees who have a prescription or Certificate
6 of Medical Necessity access to refurbished durable medical
7 equipment under this Section (excluding prosthetic and
8 orthotic devices as defined in the Orthotics, Prosthetics, and
9 Pedorthics Practice Act and complex rehabilitation technology
10 products and associated services) through the State's
11 assistive technology program's reutilization program, using
12 staff with the Assistive Technology Professional (ATP)
13 Certification if the refurbished durable medical equipment:
14 (i) is available; (ii) is less expensive, including shipping
15 costs, than new durable medical equipment of the same type;
16 (iii) is able to withstand at least 3 years of use; (iv) is
17 cleaned, disinfected, sterilized, and safe in accordance with
18 federal Food and Drug Administration regulations and guidance
19 governing the reprocessing of medical devices in health care
20 settings; and (v) equally meets the needs of the recipient or
21 enrollee. The reutilization program shall confirm that the
22 recipient or enrollee is not already in receipt of the same or
23 similar equipment from another service provider, and that the
24 refurbished durable medical equipment equally meets the needs
25 of the recipient or enrollee. Nothing in this paragraph shall
26 be construed to limit recipient or enrollee choice to obtain

1 new durable medical equipment or place any additional prior
2 authorization conditions on enrollees of managed care
3 organizations.

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

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

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

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

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

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

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

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

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

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

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

22 Because kidney transplantation can be an appropriate,
23 cost-effective alternative to renal dialysis when medically
24 necessary and notwithstanding the provisions of Section 1-11
25 of this Code, beginning October 1, 2014, the Department shall
26 cover kidney transplantation for noncitizens with end-stage

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

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

23 On or after July 1, 2015, opioid antagonists prescribed
24 for the treatment of an opioid overdose, including the
25 medication product, administration devices, and any pharmacy
26 fees or hospital fees related to the dispensing, distribution,

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

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

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

1 Practice Act, working under the general supervision of a
2 dentist and employed by a federally qualified health center.

3 Within 90 days after October 8, 2021 (the effective date
4 of Public Act 102-665) ~~this amendatory Act of the 102nd~~
5 ~~General Assembly~~, the Department shall seek federal approval
6 of a State Plan amendment to expand coverage for family
7 planning services that includes presumptive eligibility to
8 individuals whose income is at or below 208% of the federal
9 poverty level. Coverage under this Section shall be effective
10 beginning no later than December 1, 2022.

11 Subject to approval by the federal Centers for Medicare
12 and Medicaid Services of a Title XIX State Plan amendment
13 electing the Program of All-Inclusive Care for the Elderly
14 (PACE) as a State Medicaid option, as provided for by Subtitle
15 I (commencing with Section 4801) of Title IV of the Balanced
16 Budget Act of 1997 (Public Law 105-33) and Part 460
17 (commencing with Section 460.2) of Subchapter E of Title 42 of
18 the Code of Federal Regulations, PACE program services shall
19 become a covered benefit of the medical assistance program,
20 subject to criteria established in accordance with all
21 applicable laws.

22 Notwithstanding any other provision of this Code,
23 community-based pediatric palliative care from a trained
24 interdisciplinary team shall be covered under the medical
25 assistance program as provided in Section 15 of the Pediatric
26 Palliative Care Act.

1 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;
2 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article
3 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section
4 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;
5 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.
6 1-1-22; 102-665, eff. 10-8-21; revised 11-18-21.)".