1 AN ACT concerning regulation.

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

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

6 (215 ILCS 5/356g) (from Ch. 73, par. 968g)
7 (Text of Section before amendment by P.A. 99-407)
8 Sec. 356g. Mammograms; mastectomies.
9 (a) Every insurer shall provide in each group or individual
10 policy, contract, or certificate of insurance issued or renewed
11 for persons who are residents of this State, coverage for
12 screening by low-dose mammography for all women 35 years of age
13 or older for the presence of occult breast cancer within the
14 provisions of the policy, contract, or certificate. The
15 coverage shall be as follows:
16 (1) A baseline mammogram for women 35 to 39 years of
17 age.
18 (2) An annual mammogram for women 40 years of age or
19 older.
20 (3) A mammogram at the age and intervals considered
21 medically necessary by the woman's health care provider for
22 women under 40 years of age and having a family history of
23 breast cancer, prior personal history of breast cancer,

1 positive genetic testing, or other risk factors.
2 (4) A comprehensive ultrasound screening of an entire
3 breast or breasts if a mammogram demonstrates
4 heterogeneous or dense breast tissue, when medically
5 necessary as determined by a physician licensed to practice
6 medicine in all of its branches.
7 (5) A screening MRI when medically necessary, as
8 determined by a physician licensed to practice medicine in
9 all of its branches.
10 For purposes of this Section, "low-dose mammography" means
11 the x-ray examination of the breast using equipment dedicated
12 specifically for mammography, including the x-ray tube,
13 filter, compression device, and image receptor, with radiation
14 exposure delivery of less than 1 rad per breast for 2 views of
15 an average size breast. The term also includes digital
16 mammography.
17 (a-5) Coverage as described by subsection (a) shall be
18 provided at no cost to the insured and shall not be applied to
19 an annual or lifetime maximum benefit.
20 (a-10) When health care services are available through
21 contracted providers and a person does not comply with plan
22 provisions specific to the use of contracted providers, the
23 requirements of subsection (a-5) are not applicable. When a
24 person does not comply with plan provisions specific to the use
25 of contracted providers, plan provisions specific to the use of
26 non-contracted providers must be applied without distinction

for coverage required by this Section and shall be at least as favorable as for other radiological examinations covered by the policy or contract.

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

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

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

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

Care shall be determined in consultation with the attending physician and the patient. The offered coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to other benefits. When a mastectomy is performed and there is no evidence of malignancy then the offered coverage may be limited to the provision of prosthetic devices and reconstructive surgery to within 2 years after the date of the mastectomy. As

used in this Section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician.

Written notice of the availability of coverage under this Section shall be delivered to the insured upon enrollment and annually thereafter. An insurer may not deny to an insured eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this Section. An insurer may not penalize or reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with this Section.

(c) Rulemaking authority to implement Public Act 95-1045 ~~this amendatory Act of the 95th General Assembly~~, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-433, eff. 8-21-15; revised 10-20-15.)

(Text of Section after amendment by P.A. 99-407)

Sec. 356g. Mammograms; mastectomies.

(a) Every insurer shall provide in each group or individual policy, contract, or certificate of insurance issued or renewed

1 for persons who are residents of this State, coverage for
2 screening by low-dose mammography for all women 35 years of age
3 or older for the presence of occult breast cancer within the
4 provisions of the policy, contract, or certificate. The
5 coverage shall be as follows:

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

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

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

15 (4) A comprehensive ultrasound screening of an entire
16 breast or breasts if a mammogram demonstrates
17 heterogeneous or dense breast tissue, when medically
18 necessary as determined by a physician licensed to practice
19 medicine in all of its branches.

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

23 For purposes of this Section, "low-dose mammography" means
24 the x-ray examination of the breast using equipment dedicated
25 specifically for mammography, including the x-ray tube,
26 filter, compression device, and image receptor, with radiation

exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography and includes breast tomosynthesis. As used in this Section, the term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

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

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

(a-10) When health care services are available through

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

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

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

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

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

Care shall be determined in consultation with the attending physician and the patient. The offered coverage for prosthetic devices and reconstructive surgery shall be subject to the

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

Written notice of the availability of coverage under this Section shall be delivered to the insured upon enrollment and annually thereafter. An insurer may not deny to an insured eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this Section. An insurer may not penalize or reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with this Section.

(c) Rulemaking authority to implement Public Act 95-1045 ~~this amendatory Act of the 95th General Assembly~~, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

1 (Source: P.A. 99-407 (see Section 99 of P.A. 99-407 for its
2 effective date); 99-433, eff. 8-21-15; revised 10-20-15.)

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

5 (215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)
6 (Text of Section before amendment by P.A. 99-407)
7 Sec. 4-6.1. Mammograms; mastectomies.
8 (a) Every contract or evidence of coverage issued by a
9 Health Maintenance Organization for persons who are residents
10 of this State shall contain coverage for screening by low-dose
11 mammography for all women 35 years of age or older for the
12 presence of occult breast cancer. The coverage shall be as
13 follows:
14 (1) A baseline mammogram for women 35 to 39 years of
15 age.
16 (2) An annual mammogram for women 40 years of age or
17 older.
18 (3) A mammogram at the age and intervals considered
19 medically necessary by the woman's health care provider for
20 women under 40 years of age and having a family history of
21 breast cancer, prior personal history of breast cancer,
22 positive genetic testing, or other risk factors.
23 (4) A comprehensive ultrasound screening of an entire
24 breast or breasts if a mammogram demonstrates

1 heterogeneous or dense breast tissue, when medically
2 necessary as determined by a physician licensed to practice
3 medicine in all of its branches.

4 For purposes of this Section, "low-dose mammography" means
5 the x-ray examination of the breast using equipment dedicated
6 specifically for mammography, including the x-ray tube,
7 filter, compression device, and image receptor, with radiation
8 exposure delivery of less than 1 rad per breast for 2 views of
9 an average size breast. The term also includes digital
10 mammography.

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

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

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

26 (2) surgery and reconstruction of the other breast to

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

1 inconsistent with this Section.
2 (c) Rulemaking authority to implement this amendatory Act
3 of the 95th General Assembly, if any, is conditioned on the
4 rules being adopted in accordance with all provisions of the
5 Illinois Administrative Procedure Act and all rules and
6 procedures of the Joint Committee on Administrative Rules; any
7 purported rule not so adopted, for whatever reason, is
8 unauthorized.
9 (Source: P.A. 94-121, eff. 7-6-05; 95-431, eff. 8-24-07;
10 95-1045, eff. 3-27-09.)

11 (Text of Section after amendment by P.A. 99-407)
12 Sec. 4-6.1. Mammograms; mastectomies.
13 (a) Every contract or evidence of coverage issued by a
14 Health Maintenance Organization for persons who are residents
15 of this State shall contain coverage for screening by low-dose
16 mammography for all women 35 years of age or older for the
17 presence of occult breast cancer. The coverage shall be as
18 follows:
19 (1) A baseline mammogram for women 35 to 39 years of
20 age.
21 (2) An annual mammogram for women 40 years of age or
22 older.
23 (3) A mammogram at the age and intervals considered
24 medically necessary by the woman's health care provider for
25 women under 40 years of age and having a family history of

1 breast cancer, prior personal history of breast cancer,
2 positive genetic testing, or other risk factors.

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

8 For purposes of this Section, "low-dose mammography" means
9 the x-ray examination of the breast using equipment dedicated
10 specifically for mammography, including the x-ray tube,
11 filter, compression device, and image receptor, with radiation
12 exposure delivery of less than 1 rad per breast for 2 views of
13 an average size breast. The term also includes digital
14 mammography and includes breast tomosynthesis. As used in this
15 Section, the term "breast tomosynthesis" means a radiologic
16 procedure that involves the acquisition of projection images
17 over the stationary breast to produce cross-sectional digital
18 three-dimensional images of the breast.

19 If, at any time, the Secretary of the United States
20 Department of Health and Human Services, or its successor
21 agency, promulgates rules or regulations to be published in the
22 Federal Register or publishes a comment in the Federal Register
23 or issues an opinion, guidance, or other action that would
24 require the State, pursuant to any provision of the Patient
25 Protection and Affordable Care Act (Public Law 111-148),
26 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any

1 successor provision, to defray the cost of any coverage for
2 breast tomosynthesis outlined in this subsection, then the
3 requirement that an insurer cover breast tomosynthesis is
4 inoperative other than any such coverage authorized under
5 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
6 the State shall not assume any obligation for the cost of
7 coverage for breast tomosynthesis set forth in this subsection.
8 (a-5) Coverage as described in subsection (a) shall be
9 provided at no cost to the enrollee and shall not be applied to
10 an annual or lifetime maximum benefit.
11 (b) No contract or evidence of coverage issued by a health
12 maintenance organization that provides for the surgical
13 procedure known as a mastectomy shall be issued, amended,
14 delivered, or renewed in this State on or after the effective
15 date of this amendatory Act of the 92nd General Assembly unless
16 that coverage also provides for prosthetic devices or
17 reconstructive surgery incident to the mastectomy, providing
18 that the mastectomy is performed after the effective date of
19 this amendatory Act. Coverage for breast reconstruction in
20 connection with a mastectomy shall include:
21 (1) reconstruction of the breast upon which the
22 mastectomy has been performed;
23 (2) surgery and reconstruction of the other breast to
24 produce a symmetrical appearance; and
25 (3) prostheses and treatment for physical
26 complications at all stages of mastectomy, including

1 lymphedemas.
2 Care shall be determined in consultation with the attending
3 physician and the patient. The offered coverage for prosthetic
4 devices and reconstructive surgery shall be subject to the
5 deductible and coinsurance conditions applied to the
6 mastectomy and all other terms and conditions applicable to
7 other benefits. When a mastectomy is performed and there is no
8 evidence of malignancy, then the offered coverage may be
9 limited to the provision of prosthetic devices and
10 reconstructive surgery to within 2 years after the date of the
11 mastectomy. As used in this Section, "mastectomy" means the
12 removal of all or part of the breast for medically necessary
13 reasons, as determined by a licensed physician.

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

25 (c) Rulemaking authority to implement this amendatory Act
26 of the 95th General Assembly, if any, is conditioned on the

1 rules being adopted in accordance with all provisions of the
2 Illinois Administrative Procedure Act and all rules and
3 procedures of the Joint Committee on Administrative Rules; any
4 purported rule not so adopted, for whatever reason, is
5 unauthorized.
6 (Source: P.A. 99-407 (see Section 99 of P.A. 99-407 for its
7 effective date).)

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

10 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
11 (Text of Section before amendment by P.A. 99-407)
12 Sec. 5-5. Medical services. The Illinois Department, by
13 rule, shall determine the quantity and quality of and the rate
14 of reimbursement for the medical assistance for which payment
15 will be authorized, and the medical services to be provided,
16 which may include all or part of the following: (1) inpatient
17 hospital services; (2) outpatient hospital services; (3) other
18 laboratory and X-ray services; (4) skilled nursing home
19 services; (5) physicians' services whether furnished in the
20 office, the patient's home, a hospital, a skilled nursing home,
21 or elsewhere; (6) medical care, or any other type of remedial
22 care furnished by licensed practitioners; (7) home health care
23 services; (8) private duty nursing service; (9) clinic
24 services; (10) dental services, including prevention and

1 treatment of periodontal disease and dental caries disease for
2 pregnant women, provided by an individual licensed to practice
3 dentistry or dental surgery; for purposes of this item (10),
4 "dental services" means diagnostic, preventive, or corrective
5 procedures provided by or under the supervision of a dentist in
6 the practice of his or her profession; (11) physical therapy
7 and related services; (12) prescribed drugs, dentures, and
8 prosthetic devices; and eyeglasses prescribed by a physician
9 skilled in the diseases of the eye, or by an optometrist,
10 whichever the person may select; (13) other diagnostic,
11 screening, preventive, and rehabilitative services, including
12 to ensure that the individual's need for intervention or
13 treatment of mental disorders or substance use disorders or
14 co-occurring mental health and substance use disorders is
15 determined using a uniform screening, assessment, and
16 evaluation process inclusive of criteria, for children and
17 adults; for purposes of this item (13), a uniform screening,
18 assessment, and evaluation process refers to a process that
19 includes an appropriate evaluation and, as warranted, a
20 referral; "uniform" does not mean the use of a singular
21 instrument, tool, or process that all must utilize; (14)
22 transportation and such other expenses as may be necessary;
23 (15) medical treatment of sexual assault survivors, as defined
24 in Section 1a of the Sexual Assault Survivors Emergency
25 Treatment Act, for injuries sustained as a result of the sexual
26 assault, including examinations and laboratory tests to

1 discover evidence which may be used in criminal proceedings
2 arising from the sexual assault; (16) the diagnosis and
3 treatment of sickle cell anemia; and (17) any other medical
4 care, and any other type of remedial care recognized under the
5 laws of this State, but not including abortions, or induced
6 miscarriages or premature births, unless, in the opinion of a
7 physician, such procedures are necessary for the preservation
8 of the life of the woman seeking such treatment, or except an
9 induced premature birth intended to produce a live viable child
10 and such procedure is necessary for the health of the mother or
11 her unborn child. The Illinois Department, by rule, shall
12 prohibit any physician from providing medical assistance to
13 anyone eligible therefor under this Code where such physician
14 has been found guilty of performing an abortion procedure in a
15 wilful and wanton manner upon a woman who was not pregnant at
16 the time such abortion procedure was performed. The term "any
17 other type of remedial care" shall include nursing care and
18 nursing home service for persons who rely on treatment by
19 spiritual means alone through prayer for healing.

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

1 Family Services may provide the following services to persons
2 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 the
9 diseases of the eye, or by an optometrist, whichever the
10 person may select.
11 Notwithstanding any other provision of this Code and
12 subject to federal approval, the Department may adopt rules to
13 allow a dentist who is volunteering his or her service at no
14 cost to render dental services through an enrolled
15 not-for-profit health clinic without the dentist personally
16 enrolling as a participating provider in the medical assistance
17 program. A not-for-profit health clinic shall include a public
18 health clinic or Federally Qualified Health Center or other
19 enrolled provider, as determined by the Department, through
20 which dental services covered under this Section are performed.
21 The Department shall establish a process for payment of claims
22 for reimbursement for covered dental services rendered under
23 this provision.
24 The Illinois Department, by rule, may distinguish and
25 classify the medical services to be provided only in accordance
26 with the classes of persons designated in Section 5-2.

1 The Department of Healthcare and Family Services must
2 provide coverage and reimbursement for amino acid-based
3 elemental formulas, regardless of delivery method, for the
4 diagnosis and treatment of (i) eosinophilic disorders and (ii)
5 short bowel syndrome when the prescribing physician has issued
6 a written order stating that the amino acid-based elemental
7 formula is medically necessary.

8 The Illinois Department shall authorize the provision of,
9 and shall authorize payment for, screening by low-dose
10 mammography for the presence of occult breast cancer for women
11 35 years of age or older who are eligible for medical
12 assistance under this Article, as follows:

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

15 (B) An annual mammogram for women 40 years of age or
16 older.

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

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

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

All screenings shall include a physical breast exam, instruction on self-examination and information regarding the frequency of self-examination and its value as a preventative tool. For purposes of this Section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with an average radiation exposure delivery of less than one rad per breast for 2 views of an average size breast. The term also includes digital mammography.

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

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

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

1 On and after January 1, 2017, providers participating in a
2 breast cancer treatment quality improvement program approved
3 by the Department shall be reimbursed for breast cancer
4 treatment at a rate that is no lower than 95% of the Medicare
5 program's rates for the data elements included in the breast
6 cancer treatment quality program.

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

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

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

effectiveness and modifying the methodology based on the evaluation.

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

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

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

Department shall require all networks of care to include access for patients diagnosed with cancer to at least one academic commission on cancer-accredited cancer program as an in-network covered benefit.

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

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

The Illinois Department, in cooperation with the Departments of Human Services (as successor to the Department

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

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

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

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

sponsor organization be a medical organization.

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

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

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

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

Medical providers shall be required to meet certain qualifications to participate in Partnerships to ensure the delivery of high quality medical services. These

1 qualifications shall be determined by rule of the Illinois
2 Department and may be higher than qualifications for
3 participation in the medical assistance program. Partnership
4 sponsors may prescribe reasonable additional qualifications
5 for participation by medical providers, only with the prior
6 written approval of the Illinois Department.

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

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

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

and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after September 16, 1984 (the effective date of Public Act 83-1439) ~~this amendatory Act of 1984~~, the Illinois Department shall establish a current list of

acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

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

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

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

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

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

25 Enrollment of a vendor shall be subject to a provisional
26 period and shall be conditional for one year. During the period

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

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

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

The Department shall define or specify the following: (i) by provider notice, the "category of risk of the vendor" for each type of vendor, which shall take into account the level of screening applicable to a particular category of vendor under

federal law and regulations; (ii) by rule or provider notice, the maximum length of the conditional enrollment period for each category of risk of the vendor; and (iii) by rule, the hearing rights, if any, afforded to a vendor in each category of risk of the vendor that is terminated or disenrolled during the conditional enrollment period.

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

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

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

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

(4) In the case of a provider operated by a unit of

1 local government with a population exceeding 3,000,000
2 when local government funds finance federal participation
3 for claims payments.

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

11 In the case of long term care facilities, within 5 days of
12 receipt by the facility of required prescreening information,
13 data for new admissions shall be entered into the Medical
14 Electronic Data Interchange (MEDI) or the Recipient
15 Eligibility Verification (REV) System or successor system, and
16 within 15 days of receipt by the facility of required
17 prescreening information, admission documents shall be
18 submitted through MEDI or REV or shall be submitted directly to
19 the Department of Human Services using required admission
20 forms. Effective September 1, 2014, admission documents,
21 including all prescreening information, must be submitted
22 through MEDI or REV. Confirmation numbers assigned to an
23 accepted transaction shall be retained by a facility to verify
24 timely submittal. Once an admission transaction has been
25 completed, all resubmitted claims following prior rejection
26 are subject to receipt no later than 180 days after the

1 admission transaction has been completed.

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

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

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

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

1 durable medical equipment. Such rules shall provide, but not be
2 limited to, the following services: (1) immediate repair or
3 replacement of such devices by recipients; and (2) rental,
4 lease, purchase or lease-purchase of durable medical equipment
5 in a cost-effective manner, taking into consideration the
6 recipient's medical prognosis, the extent of the recipient's
7 needs, and the requirements and costs for maintaining such
8 equipment. Subject to prior approval, such rules shall enable a
9 recipient to temporarily acquire and use alternative or
10 substitute devices or equipment pending repairs or
11 replacements of any device or equipment previously authorized
12 for such recipient by the Department.

13 The Department shall execute, relative to the nursing home
14 prescreening project, written inter-agency agreements with the
15 Department of Human Services and the Department on Aging, to
16 effect the following: (i) intake procedures and common
17 eligibility criteria for those persons who are receiving
18 non-institutional services; and (ii) the establishment and
19 development of non-institutional services in areas of the State
20 where they are not currently available or are undeveloped; and
21 (iii) notwithstanding any other provision of law, subject to
22 federal approval, on and after July 1, 2012, an increase in the
23 determination of need (DON) scores from 29 to 37 for applicants
24 for institutional and home and community-based long term care;
25 if and only if federal approval is not granted, the Department
26 may, in conjunction with other affected agencies, implement

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

17 The Illinois Department shall develop and operate, in
18 cooperation with other State Departments and agencies and in
19 compliance with applicable federal laws and regulations,
20 appropriate and effective systems of health care evaluation and
21 programs for monitoring of utilization of health care services
22 and facilities, as it affects persons eligible for medical
23 assistance under this Code.

24 The Illinois Department shall report annually to the
25 General Assembly, no later than the second Friday in April of
26 1979 and each year thereafter, in regard to:

1 (a) actual statistics and trends in utilization of
2 medical services by public aid recipients;
3 (b) actual statistics and trends in the provision of
4 the various medical services by medical vendors;
5 (c) current rate structures and proposed changes in
6 those rate structures for the various medical vendors; and
7 (d) efforts at utilization review and control by the
8 Illinois Department.
9 The period covered by each report shall be the 3 years
10 ending on the June 30 prior to the report. The report shall
11 include suggested legislation for consideration by the General
12 Assembly. The filing of one copy of the report with the
13 Speaker, one copy with the Minority Leader and one copy with
14 the Clerk of the House of Representatives, one copy with the
15 President, one copy with the Minority Leader and one copy with
16 the Secretary of the Senate, one copy with the Legislative
17 Research Unit, and such additional copies with the State
18 Government Report Distribution Center for the General Assembly
19 as is required under paragraph (t) of Section 7 of the State
20 Library Act shall be deemed sufficient to comply with this
21 Section.
22 Rulemaking authority to implement Public Act 95-1045, if
23 any, is conditioned on the rules being adopted in accordance
24 with all provisions of the Illinois Administrative Procedure
25 Act and all rules and procedures of the Joint Committee on
26 Administrative Rules; any purported rule not so adopted, for

1 whatever reason, is unauthorized.

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

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

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

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

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

20 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
21 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
22 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
23 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
24 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-433, eff.
25 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

(Text of Section after amendment by P.A. 99-407)

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere; (6) medical care, or any other type of remedial care furnished by licensed practitioners; (7) home health care services; (8) private duty nursing service; (9) clinic services; (10) dental services, including prevention and treatment of periodontal disease and dental caries disease for pregnant women, provided by an individual licensed to practice dentistry or dental surgery; for purposes of this item (10), "dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession; (11) physical therapy and related services; (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select; (13) other diagnostic, screening, preventive, and rehabilitative services, including to ensure that the individual's need for intervention or

1 treatment of mental disorders or substance use disorders or
2 co-occurring mental health and substance use disorders is
3 determined using a uniform screening, assessment, and
4 evaluation process inclusive of criteria, for children and
5 adults; for purposes of this item (13), a uniform screening,
6 assessment, and evaluation process refers to a process that
7 includes an appropriate evaluation and, as warranted, a
8 referral; "uniform" does not mean the use of a singular
9 instrument, tool, or process that all must utilize; (14)
10 transportation and such other expenses as may be necessary;
11 (15) medical treatment of sexual assault survivors, as defined
12 in Section 1a of the Sexual Assault Survivors Emergency
13 Treatment Act, for injuries sustained as a result of the sexual
14 assault, including examinations and laboratory tests to
15 discover evidence which may be used in criminal proceedings
16 arising from the sexual assault; (16) the diagnosis and
17 treatment of sickle cell anemia; and (17) any other medical
18 care, and any other type of remedial care recognized under the
19 laws of this State, but not including abortions, or induced
20 miscarriages or premature births, unless, in the opinion of a
21 physician, such procedures are necessary for the preservation
22 of the life of the woman seeking such treatment, or except an
23 induced premature birth intended to produce a live viable child
24 and such procedure is necessary for the health of the mother or
25 her unborn child. The Illinois Department, by rule, shall
26 prohibit any physician from providing medical assistance to

1 anyone eligible therefor under this Code where such physician
2 has been found guilty of performing an abortion procedure in a
3 wilful and wanton manner upon a woman who was not pregnant at
4 the time such abortion procedure was performed. The term "any
5 other type of remedial care" shall include nursing care and
6 nursing home service for persons who rely on treatment by
7 spiritual means alone through prayer for healing.

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

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

22 Upon receipt of federal approval of an amendment to the
23 Illinois Title XIX State Plan for this purpose, the Department
24 shall authorize the Chicago Public Schools (CPS) to procure a
25 vendor or vendors to manufacture eyeglasses for individuals
26 enrolled in a school within the CPS system. CPS shall ensure

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

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

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

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

Notwithstanding any other provision of this Code and subject to federal approval, the Department may adopt rules to

allow a dentist who is volunteering his or her service at no cost to render dental services through an enrolled not-for-profit health clinic without the dentist personally enrolling as a participating provider in the medical assistance program. A not-for-profit health clinic shall include a public health clinic or Federally Qualified Health Center or other enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

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

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

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

1 (A) A baseline mammogram for women 35 to 39 years of
2 age.
3 (B) An annual mammogram for women 40 years of age or
4 older.
5 (C) A mammogram at the age and intervals considered
6 medically necessary by the woman's health care provider for
7 women under 40 years of age and having a family history of
8 breast cancer, prior personal history of breast cancer,
9 positive genetic testing, or other risk factors.
10 (D) A comprehensive ultrasound screening of an entire
11 breast or breasts if a mammogram demonstrates
12 heterogeneous or dense breast tissue, when medically
13 necessary as determined by a physician licensed to practice
14 medicine in all of its branches.
15 (E) A screening MRI when medically necessary, as
16 determined by a physician licensed to practice medicine in
17 all of its branches.
18 All screenings shall include a physical breast exam,
19 instruction on self-examination and information regarding the
20 frequency of self-examination and its value as a preventative
21 tool. For purposes of this Section, "low-dose mammography"
22 means the x-ray examination of the breast using equipment
23 dedicated specifically for mammography, including the x-ray
24 tube, filter, compression device, and image receptor, with an
25 average radiation exposure delivery of less than one rad per
26 breast for 2 views of an average size breast. The term also

1 includes digital mammography and includes breast
2 tomosynthesis. As used in this Section, the term "breast
3 tomosynthesis" means a radiologic procedure that involves the
4 acquisition of projection images over the stationary breast to
5 produce cross-sectional digital three-dimensional images of
6 the breast. If, at any time, the Secretary of the United States
7 Department of Health and Human Services, or its successor
8 agency, promulgates rules or regulations to be published in the
9 Federal Register or publishes a comment in the Federal Register
10 or issues an opinion, guidance, or other action that would
11 require the State, pursuant to any provision of the Patient
12 Protection and Affordable Care Act (Public Law 111-148),
13 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
14 successor provision, to defray the cost of any coverage for
15 breast tomosynthesis outlined in this paragraph, then the
16 requirement that an insurer cover breast tomosynthesis is
17 inoperative other than any such coverage authorized under
18 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
19 the State shall not assume any obligation for the cost of
20 coverage for breast tomosynthesis set forth in this paragraph.
21 On and after January 1, 2016, the Department shall ensure
22 that all networks of care for adult clients of the Department
23 include access to at least one breast imaging Center of Imaging
24 Excellence as certified by the American College of Radiology.
25 On and after January 1, 2012, providers participating in a
26 quality improvement program approved by the Department shall be

1 reimbursed for screening and diagnostic mammography at the same
2 rate as the Medicare program's rates, including the increased
3 reimbursement for digital mammography.
4 The Department shall convene an expert panel including
5 representatives of hospitals, free-standing mammography
6 facilities, and doctors, including radiologists, to establish
7 quality standards for mammography.
8 On and after January 1, 2017, providers participating in a
9 breast cancer treatment quality improvement program approved
10 by the Department shall be reimbursed for breast cancer
11 treatment at a rate that is no lower than 95% of the Medicare
12 program's rates for the data elements included in the breast
13 cancer treatment quality program.
14 The Department shall convene an expert panel, including
15 representatives of hospitals, free standing breast cancer
16 treatment centers, breast cancer quality organizations, and
17 doctors, including breast surgeons, reconstructive breast
18 surgeons, oncologists, and primary care providers to establish
19 quality standards for breast cancer treatment.
20 Subject to federal approval, the Department shall
21 establish a rate methodology for mammography at federally
22 qualified health centers and other encounter-rate clinics.
23 These clinics or centers may also collaborate with other
24 hospital-based mammography facilities. By January 1, 2016, the
25 Department shall report to the General Assembly on the status
26 of the provision set forth in this paragraph.

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

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

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality related to breast cancer. At least one pilot program site shall be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. On or after July 1, 2016, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within metropolitan Chicago. An evaluation of the pilot program shall be carried out measuring

1 health outcomes and cost of care for those served by the pilot
2 program compared to similarly situated patients who are not
3 served by the pilot program.

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

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

24 All medical providers providing medical assistance to
25 pregnant women under this Code shall receive information from
26 the Department on the availability of services under the Drug

1 Free Families with a Future or any comparable program providing
2 case management services for addicted women, including
3 information on appropriate referrals for other social services
4 that may be needed by addicted women in addition to treatment
5 for addiction.

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

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

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

26 The Illinois Department may develop and contract with

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

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

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

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

1 (3) Persons receiving medical services through
2 Partnerships may receive medical and case management
3 services above the level usually offered through the
4 medical assistance program.
5 Medical providers shall be required to meet certain
6 qualifications to participate in Partnerships to ensure the
7 delivery of high quality medical services. These
8 qualifications shall be determined by rule of the Illinois
9 Department and may be higher than qualifications for
10 participation in the medical assistance program. Partnership
11 sponsors may prescribe reasonable additional qualifications
12 for participation by medical providers, only with the prior
13 written approval of the Illinois Department.
14 Nothing in this Section shall limit the free choice of
15 practitioners, hospitals, and other providers of medical
16 services by clients. In order to ensure patient freedom of
17 choice, the Illinois Department shall immediately promulgate
18 all rules and take all other necessary actions so that provided
19 services may be accessed from therapeutically certified
20 optometrists to the full extent of the Illinois Optometric
21 Practice Act of 1987 without discriminating between service
22 providers.
23 The Department shall apply for a waiver from the United
24 States Health Care Financing Administration to allow for the
25 implementation of Partnerships under this Section.
26 The Illinois Department shall require health care

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

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

14 The rules and regulations of the Illinois Department shall
15 require that a written statement including the required opinion
16 of a physician shall accompany any claim for reimbursement for
17 abortions, or induced miscarriages or premature births. This
18 statement shall indicate what procedures were used in providing
19 such medical services.

20 Notwithstanding any other law to the contrary, the Illinois
21 Department shall, within 365 days after July 22, 2013 (the
22 effective date of Public Act 98-104), establish procedures to
23 permit skilled care facilities licensed under the Nursing Home
24 Care Act to submit monthly billing claims for reimbursement
25 purposes. Following development of these procedures, the
26 Department shall, by July 1, 2016, test the viability of the

new system and implement any necessary operational or structural changes to its information technology platforms in order to allow for the direct acceptance and payment of nursing home claims.

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

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

The Illinois Department may require that all dispensers of medical services desiring to participate in the medical assistance program established under this Article disclose,

1 under such terms and conditions as the Illinois Department may
2 by rule establish, all inquiries from clients and attorneys
3 regarding medical bills paid by the Illinois Department, which
4 inquiries could indicate potential existence of claims or liens
5 for the Illinois Department.

6 Enrollment of a vendor shall be subject to a provisional
7 period and shall be conditional for one year. During the period
8 of conditional enrollment, the Department may terminate the
9 vendor's eligibility to participate in, or may disenroll the
10 vendor from, the medical assistance program without cause.
11 Unless otherwise specified, such termination of eligibility or
12 disenrollment is not subject to the Department's hearing
13 process. However, a disenrolled vendor may reapply without
14 penalty.

15 The Department has the discretion to limit the conditional
16 enrollment period for vendors based upon category of risk of
17 the vendor.

18 Prior to enrollment and during the conditional enrollment
19 period in the medical assistance program, all vendors shall be
20 subject to enhanced oversight, screening, and review based on
21 the risk of fraud, waste, and abuse that is posed by the
22 category of risk of the vendor. The Illinois Department shall
23 establish the procedures for oversight, screening, and review,
24 which may include, but need not be limited to: criminal and
25 financial background checks; fingerprinting; license,
26 certification, and authorization verifications; unscheduled or

unannounced site visits; database checks; prepayment audit reviews; audits; payment caps; payment suspensions; and other screening as required by federal or State law.

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

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

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

(2) In the case of errors attributable to the Illinois

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

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

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

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

In the case of long term care facilities, within 5 days of receipt by the facility of required prescreening information, data for new admissions shall be entered into the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System or successor system, and within 15 days of receipt by the facility of required prescreening information, admission documents shall be submitted through MEDI or REV or shall be submitted directly to the Department of Human Services using required admission

1 forms. Effective September 1, 2014, admission documents,
2 including all prescreening information, must be submitted
3 through MEDI or REV. Confirmation numbers assigned to an
4 accepted transaction shall be retained by a facility to verify
5 timely submittal. Once an admission transaction has been
6 completed, all resubmitted claims following prior rejection
7 are subject to receipt no later than 180 days after the
8 admission transaction has been completed.

9 Claims that are not submitted and received in compliance
10 with the foregoing requirements shall not be eligible for
11 payment under the medical assistance program, and the State
12 shall have no liability for payment of those claims.

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

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

17 Beginning in fiscal year 2013, the Illinois Department
18 shall set forth a request for information to identify the
19 benefits of a pre-payment, post-adjudication, and post-edit
20 claims system with the goals of streamlining claims processing
21 and provider reimbursement, reducing the number of pending or
22 rejected claims, and helping to ensure a more transparent
23 adjudication process through the utilization of: (i) provider
24 data verification and provider screening technology; and (ii)
25 clinical code editing; and (iii) pre-pay, pre- or
26 post-adjudicated predictive modeling with an integrated case

management system with link analysis. Such a request for information shall not be considered as a request for proposal or as an obligation on the part of the Illinois Department to take any action or acquire any products or services.

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

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

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

24 The Illinois Department shall develop and operate, in
25 cooperation with other State Departments and agencies and in
26 compliance with applicable federal laws and regulations,

1 appropriate and effective systems of health care evaluation and
2 programs for monitoring of utilization of health care services
3 and facilities, as it affects persons eligible for medical
4 assistance under this Code.

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

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

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

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

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

16 The period covered by each report shall be the 3 years
17 ending on the June 30 prior to the report. The report shall
18 include suggested legislation for consideration by the General
19 Assembly. The filing of one copy of the report with the
20 Speaker, one copy with the Minority Leader and one copy with
21 the Clerk of the House of Representatives, one copy with the
22 President, one copy with the Minority Leader and one copy with
23 the Secretary of the Senate, one copy with the Legislative
24 Research Unit, and 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 shall be deemed sufficient to comply with this
2 Section.
3 Rulemaking authority to implement Public Act 95-1045, if
4 any, is conditioned on the rules being adopted in accordance
5 with all provisions of the Illinois Administrative Procedure
6 Act and all rules and procedures of the Joint Committee on
7 Administrative Rules; any purported rule not so adopted, for
8 whatever reason, is unauthorized.
9 On and after July 1, 2012, the Department shall reduce any
10 rate of reimbursement for services or other payments or alter
11 any methodologies authorized by this Code to reduce any rate of
12 reimbursement for services or other payments in accordance with
13 Section 5-5e.
14 Because kidney transplantation can be an appropriate, cost
15 effective alternative to renal dialysis when medically
16 necessary and notwithstanding the provisions of Section 1-11 of
17 this Code, beginning October 1, 2014, the Department shall
18 cover kidney transplantation for noncitizens with end-stage
19 renal disease who are not eligible for comprehensive medical
20 benefits, who meet the residency requirements of Section 5-3 of
21 this Code, and who would otherwise meet the financial
22 requirements of the appropriate class of eligible persons under
23 Section 5-2 of this Code. To qualify for coverage of kidney
24 transplantation, such person must be receiving emergency renal
25 dialysis services covered by the Department. Providers under
26 this Section shall be prior approved and certified by the

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

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

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

(Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15; 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section 99 of P.A. 99-407 for its effective date); 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

Section 20. "An Act concerning regulation", approved August 19, 2015, Public Act 99-407, is amended by changing Section 99 as follows:

(P.A. 99-407, Sec. 99)

Sec. 99. Effective date. This Act takes effect on July 1, 2016. ~~, if and only if on or before July 1, 2016:~~

~~(1) the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations published in the Federal Register or publishes a comment in the Federal Register:~~

~~(A) repealing, amending, or reinterpreting 45 CFR 155.170 to eliminate the State's responsibility to defray the cost of a state-mandated benefit enacted on or after January 1, 2012;~~

~~(B) requiring qualified health plans, as defined in the federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act~~

~~of 2010 and any subsequent amendatory Acts, rules, or regulations issued pursuant thereto, to cover breast tomosynthesis as an essential health benefit; or~~

~~(C) including breast tomosynthesis as a standard as part of the essential health benefits required of benchmark plans under 45 CFR 156.110; or~~

~~(2) the federal Patient Protection and Affordable Care Act is repealed by an Act of Congress or is invalidated by a decision of the U.S. Supreme Court.~~

(Source: P.A. 99-407, eff. (see Section 99 of P.A. 99-407 for its effective date).)

Section 95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

Section 99. Effective date. This Act takes effect on July 1, 2016.