Sen. John G. Mulroe

Filed: 4/15/2016

1 AMENDMENT TO SENATE BILL 466

2 AMENDMENT NO. ______. Amend Senate Bill 466 by replacing
3 everything after the enacting clause with the following:

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

age.

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

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

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

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

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 radiation exposure delivery of less than 1 rad per breast for 2 views of an average size breast. The term also includes digital mammography.

(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 <u>Public Act 95-1045</u> ~~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,

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

3 (Text of Section after amendment by P.A. 99-407)
4 Sec. 356g. Mammograms; mastectomies.
5 (a) Every insurer shall provide in each group or individual
6 policy, contract, or certificate of insurance issued or renewed
7 for persons who are residents of this State, coverage for
8 screening by low-dose mammography for all women 35 years of age
9 or older for the presence of occult breast cancer within the
10 provisions of the policy, contract, or certificate. The
11 coverage shall be as follows:
12 (1) A baseline mammogram for women 35 to 39 years of
13 age.
14 (2) An annual mammogram for women 40 years of age or
15 older.
16 (3) A mammogram at the age and intervals considered
17 medically necessary by the woman's health care provider for
18 women under 40 years of age and having a family history of
19 breast cancer, prior personal history of breast cancer,
20 positive genetic testing, or other risk factors.
21 (4) A comprehensive ultrasound screening of an entire
22 breast or breasts if a mammogram demonstrates
23 heterogeneous or dense breast tissue, when medically
24 necessary as determined by a physician licensed to practice
25 medicine in all of its branches.

1 (5) A screening MRI when medically necessary, as
2 determined by a physician licensed to practice medicine in
3 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 and includes breast tomosynthesis. As used in this
11 Section, the term "breast tomosynthesis" means a radiologic
12 procedure that involves the acquisition of projection images
13 over the stationary breast to produce cross-sectional digital
14 three-dimensional images of the breast.
15 If, at any time, the Secretary of the United States
16 Department of Health and Human Services, or its successor
17 agency, promulgates rules or regulations to be published in the
18 Federal Register or publishes a comment in the Federal Register
19 or issues an opinion, guidance, or other action that would
20 require the State, pursuant to any provision of the Patient
21 Protection and Affordable Care Act (Public Law 111-148),
22 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
23 successor provision, to defray the cost of any coverage for
24 screening by breast tomosynthesis outlined in this subsection,
25 then the requirement that an insurer cover screening by breast
26 tomosynthesis is inoperative other than any such coverage

1 authorized under Section 1902 of the Social Security Act, 42
2 U.S.C. 1396a, and the State shall not assume any obligation for
3 the cost of coverage for screening by breast tomosynthesis set
4 forth in this subsection.

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

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

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

25 (1) reconstruction of the breast upon which the
26 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 <u>Public Act 95-1045</u> ~~this amendatory Act of the 95th General Assembly~~, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

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

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

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

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

Sec. 4-6.1. Mammograms; mastectomies.

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

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

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

1 older.

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

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

12 For purposes of this Section, "low-dose mammography" means
13 the x-ray examination of the breast using equipment dedicated
14 specifically for mammography, including the x-ray tube,
15 filter, compression device, and image receptor, with radiation
16 exposure delivery of less than 1 rad per breast for 2 views of
17 an average size breast. The term also includes digital
18 mammography.

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

22 (b) No contract or evidence of coverage issued by a health
23 maintenance organization that provides for the surgical
24 procedure known as a mastectomy shall be issued, amended,
25 delivered, or renewed in this State on or after the effective
26 date of this amendatory Act of the 92nd General Assembly unless

that coverage also provides for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that the mastectomy is performed after the effective date of this amendatory Act. Coverage for breast reconstruction in connection with a mastectomy shall include:

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

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

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

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

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

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

(Source: P.A. 94-121, eff. 7-6-05; 95-431, eff. 8-24-07; 95-1045, eff. 3-27-09.)

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

Sec. 4-6.1. Mammograms; mastectomies.

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

follows:

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

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

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

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

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 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.

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

that the mastectomy is performed after the effective date of this amendatory Act. Coverage for breast reconstruction in connection with a mastectomy shall include:

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

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

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

Care shall be determined in consultation with the attending physician and the patient. The offered coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits. When a mastectomy is performed and there is no 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 enrollee upon enrollment and annually thereafter. A health maintenance organization may not deny to an enrollee 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. A health maintenance organization may not penalize or reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with this Section.

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

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

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

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

(Text of Section before 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 treatment of mental disorders or substance use disorders or co-occurring mental health and substance use disorders is determined using a uniform screening, assessment, and evaluation process inclusive of criteria, for children and adults; for purposes of this item (13), a uniform screening,

1 assessment, and evaluation process refers to a process that
2 includes an appropriate evaluation and, as warranted, a
3 referral; "uniform" does not mean the use of a singular
4 instrument, tool, or process that all must utilize; (14)
5 transportation and such other expenses as may be necessary;
6 (15) medical treatment of sexual assault survivors, as defined
7 in Section 1a of the Sexual Assault Survivors Emergency
8 Treatment Act, for injuries sustained as a result of the sexual
9 assault, including examinations and laboratory tests to
10 discover evidence which may be used in criminal proceedings
11 arising from the sexual assault; (16) the diagnosis and
12 treatment of sickle cell anemia; and (17) any other medical
13 care, and any other type of remedial care recognized under the
14 laws of this State, but not including abortions, or induced
15 miscarriages or premature births, unless, in the opinion of a
16 physician, such procedures are necessary for the preservation
17 of the life of the woman seeking such treatment, or except an
18 induced premature birth intended to produce a live viable child
19 and such procedure is necessary for the health of the mother or
20 her unborn child. The Illinois Department, by rule, shall
21 prohibit any physician from providing medical assistance to
22 anyone eligible therefor under this Code where such physician
23 has been found guilty of performing an abortion procedure in a
24 wilful and wanton manner upon a woman who was not pregnant at
25 the time such abortion procedure was performed. The term "any
26 other type of remedial care" shall include nursing care and

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

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

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

(C) A mammogram at the age and intervals considered

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

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

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

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.

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

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

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other hospital-based mammography facilities. By January 1, 2016, the

Department shall report to the General Assembly on the status 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 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

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

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

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

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

1 procedures to the Illinois Department.
2 The Illinois Department may develop and contract with
3 Partnerships of medical providers to arrange medical services
4 for persons eligible under Section 5-2 of this Code.
5 Implementation of this Section may be by demonstration projects
6 in certain geographic areas. The Partnership shall be
7 represented by a sponsor organization. The Department, by rule,
8 shall develop qualifications for sponsors of Partnerships.
9 Nothing in this Section shall be construed to require that the
10 sponsor organization be a medical organization.
11 The sponsor must negotiate formal written contracts with
12 medical providers for physician services, inpatient and
13 outpatient hospital care, home health services, treatment for
14 alcoholism and substance abuse, and other services determined
15 necessary by the Illinois Department by rule for delivery by
16 Partnerships. Physician services must include prenatal and
17 obstetrical care. The Illinois Department shall reimburse
18 medical services delivered by Partnership providers to clients
19 in target areas according to provisions of this Article and the
20 Illinois Health Finance Reform Act, except that:
21 (1) Physicians participating in a Partnership and
22 providing certain services, which shall be determined by
23 the Illinois Department, to persons in areas covered by the
24 Partnership may receive an additional surcharge for such
25 services.
26 (2) The Department may elect to consider and negotiate

financial incentives to encourage the development of Partnerships and the efficient delivery of medical care.

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

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

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

The Department shall apply for a waiver from the United States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.
2 The Illinois Department shall require health care
3 providers to maintain records that document the medical care
4 and services provided to recipients of Medical Assistance under
5 this Article. Such records must be retained for a period of not
6 less than 6 years from the date of service or as provided by
7 applicable State law, whichever period is longer, except that
8 if an audit is initiated within the required retention period
9 then the records must be retained until the audit is completed
10 and every exception is resolved. The Illinois Department shall
11 require health care providers to make available, when
12 authorized by the patient, in writing, the medical records in a
13 timely fashion to other health care providers who are treating
14 or serving persons eligible for Medical Assistance under this
15 Article. All dispensers of medical services shall be required
16 to maintain and retain business and professional records
17 sufficient to fully and accurately document the nature, scope,
18 details and receipt of the health care provided to persons
19 eligible for medical assistance under this Code, in accordance
20 with regulations promulgated by the Illinois Department. The
21 rules and regulations shall require that proof of the receipt
22 of prescription drugs, dentures, prosthetic devices and
23 eyeglasses by eligible persons under this Section accompany
24 each claim for reimbursement submitted by the dispenser of such
25 medical services. No such claims for reimbursement shall be
26 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

1 purposes. Following development of these procedures, the
2 Department shall, by July 1, 2016, test the viability of the
3 new system and implement any necessary operational or
4 structural changes to its information technology platforms in
5 order to allow for the direct acceptance and payment of nursing
6 home claims.

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

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

26 The Illinois Department may require that all dispensers of

1 medical services desiring to participate in the medical
2 assistance program established under this Article disclose,
3 under such terms and conditions as the Illinois Department may
4 by rule establish, all inquiries from clients and attorneys
5 regarding medical bills paid by the Illinois Department, which
6 inquiries could indicate potential existence of claims or liens
7 for the Illinois Department.

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

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

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

1 financial background checks; fingerprinting; license,
2 certification, and authorization verifications; unscheduled or
3 unannounced site visits; database checks; prepayment audit
4 reviews; audits; payment caps; payment suspensions; and other
5 screening as required by federal or State law.
6 The Department shall define or specify the following: (i)
7 by provider notice, the "category of risk of the vendor" for
8 each type of vendor, which shall take into account the level of
9 screening applicable to a particular category of vendor under
10 federal law and regulations; (ii) by rule or provider notice,
11 the maximum length of the conditional enrollment period for
12 each category of risk of the vendor; and (iii) by rule, the
13 hearing rights, if any, afforded to a vendor in each category
14 of risk of the vendor that is terminated or disenrolled during
15 the conditional enrollment period.
16 To be eligible for payment consideration, a vendor's
17 payment claim or bill, either as an initial claim or as a
18 resubmitted claim following prior rejection, must be received
19 by the Illinois Department, or its fiscal intermediary, no
20 later than 180 days after the latest date on the claim on which
21 medical goods or services were provided, with the following
22 exceptions:
23 (1) In the case of a provider whose enrollment is in
24 process by the Illinois Department, the 180-day period
25 shall not begin until the date on the written notice from
26 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 forms. Effective September 1, 2014, admission documents, including all prescreening information, must be submitted through MEDI or REV. Confirmation numbers assigned to an accepted transaction shall be retained by a facility to verify timely submittal. Once an admission transaction has been completed, all resubmitted claims following prior rejection are subject to receipt no later than 180 days after the admission transaction has been completed.

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

To the extent consistent with applicable information and privacy, security, and disclosure laws, State and federal agencies and departments shall provide the Illinois Department access to confidential and other information and data necessary to perform eligibility and payment verifications and other Illinois Department functions. This includes, but is not limited to: information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency

1 exclusions; taxpayer identification numbers; tax delinquency;
2 corporate information; and death records.
3 The Illinois Department shall enter into agreements with
4 State agencies and departments, and is authorized to enter into
5 agreements with federal agencies and departments, under which
6 such agencies and departments shall share data necessary for
7 medical assistance program integrity functions and oversight.
8 The Illinois Department shall develop, in cooperation with
9 other State departments and agencies, and in compliance with
10 applicable federal laws and regulations, appropriate and
11 effective methods to share such data. At a minimum, and to the
12 extent necessary to provide data sharing, the Illinois
13 Department shall enter into agreements with State agencies and
14 departments, and is authorized to enter into agreements with
15 federal agencies and departments, including but not limited to:
16 the Secretary of State; the Department of Revenue; the
17 Department of Public Health; the Department of Human Services;
18 and the Department of Financial and Professional Regulation.
19 Beginning in fiscal year 2013, the Illinois Department
20 shall set forth a request for information to identify the
21 benefits of a pre-payment, post-adjudication, and post-edit
22 claims system with the goals of streamlining claims processing
23 and provider reimbursement, reducing the number of pending or
24 rejected claims, and helping to ensure a more transparent
25 adjudication process through the utilization of: (i) provider
26 data verification and provider screening technology; and (ii)

1 clinical code editing; and (iii) pre-pay, pre- or
2 post-adjudicated predictive modeling with an integrated case
3 management system with link analysis. Such a request for
4 information shall not be considered as a request for proposal
5 or as an obligation on the part of the Illinois Department to
6 take any action or acquire any products or services.

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

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

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

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

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

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

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

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

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

18 The period covered by each report shall be the 3 years
19 ending on the June 30 prior to the report. The report shall
20 include suggested legislation for consideration by the General
21 Assembly. The filing of one copy of the report with the
22 Speaker, one copy with the Minority Leader and one copy with
23 the Clerk of the House of Representatives, one copy with the
24 President, one copy with the Minority Leader and one copy with
25 the Secretary of the Senate, one copy with the Legislative
26 Research Unit, and such additional copies with the State

Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act shall be deemed sufficient to comply with this Section.

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

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

Because kidney transplantation can be an appropriate, cost effective alternative to renal dialysis when medically necessary and notwithstanding the provisions of Section 1-11 of this Code, beginning October 1, 2014, the Department shall cover kidney transplantation for noncitizens with end-stage renal disease who are not eligible for comprehensive medical benefits, who meet the residency requirements of Section 5-3 of this Code, and who would otherwise meet the financial requirements of the appropriate class of eligible persons under Section 5-2 of this Code. To qualify for coverage of kidney transplantation, such person must be receiving emergency renal

1 dialysis services covered by the Department. Providers under
2 this Section shall be prior approved and certified by the
3 Department to perform kidney transplantation and the services
4 under this Section shall be limited to services associated with
5 kidney transplantation.

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

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

1 other similarly acting drug approved by the U.S. Food and Drug
2 Administration.
3 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;
4 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.
5 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,
6 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;
7 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-433, eff.
8 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

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

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

care, and any other type of remedial care recognized under the laws of this State, but not including abortions, or induced miscarriages or premature births, unless, in the opinion of a physician, such procedures are necessary for the preservation of the life of the woman seeking such treatment, or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. The Illinois Department, by rule, shall prohibit any physician from providing medical assistance to anyone eligible therefor under this Code where such physician has been found guilty of performing an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

Notwithstanding any other provision of this Code, the Illinois Department may not require, as a condition of payment for any laboratory test authorized under this Article, that a

1 physician's handwritten signature appear on the laboratory
2 test order form. The Illinois Department may, however, impose
3 other appropriate requirements regarding laboratory test order
4 documentation.

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

23 On and after July 1, 2012, the Department of Healthcare and
24 Family Services may provide the following services to persons
25 eligible for assistance under this Article who are
26 participating in education, training or employment programs

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

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

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

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

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

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

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 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. <u>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 screening by breast tomosynthesis outlined in this paragraph, then the requirement that an insurer cover screening by breast tomosynthesis is inoperative other than any such coverage</u>

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 screening by breast tomosynthesis set forth in this paragraph.

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.

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

The Department shall convene an expert panel, including representatives of hospitals, free standing breast cancer treatment centers, breast cancer quality organizations, and

1 doctors, including breast surgeons, reconstructive breast
2 surgeons, oncologists, and primary care providers to establish
3 quality standards for breast cancer treatment.

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

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

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

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

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

1 The Illinois Department shall establish such regulations
2 governing the dispensing of health services under this Article
3 as it shall deem appropriate. The Department should seek the
4 advice of formal professional advisory committees appointed by
5 the Director of the Illinois Department for the purpose of
6 providing regular advice on policy and administrative matters,
7 information dissemination and educational activities for
8 medical and health care providers, and consistency in
9 procedures to the Illinois Department.
10 The Illinois Department may develop and contract with
11 Partnerships of medical providers to arrange medical services
12 for persons eligible under Section 5-2 of this Code.
13 Implementation of this Section may be by demonstration projects
14 in certain geographic areas. The Partnership shall be
15 represented by a sponsor organization. The Department, by rule,
16 shall develop qualifications for sponsors of Partnerships.
17 Nothing in this Section shall be construed to require that the
18 sponsor organization be a medical organization.
19 The sponsor must negotiate formal written contracts with
20 medical providers for physician services, inpatient and
21 outpatient hospital care, home health services, treatment for
22 alcoholism and substance abuse, and other services determined
23 necessary by the Illinois Department by rule for delivery by
24 Partnerships. Physician services must include prenatal and
25 obstetrical care. The Illinois Department shall reimburse
26 medical services delivered by Partnership providers to clients

in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

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

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

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

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

Nothing in this Section shall limit the free choice of practitioners, hospitals, and other providers of medical services by clients. In order to ensure patient freedom of

choice, the Illinois Department shall immediately promulgate all rules and take all other necessary actions so that provided services may be accessed from therapeutically certified optometrists to the full extent of the Illinois Optometric Practice Act of 1987 without discriminating between service providers.

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall 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 <u>September 16, 1984 (</u>the effective date of <u>Public Act 83-1439)</u> ~~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

1 abortions, or induced miscarriages or premature births. This
2 statement shall indicate what procedures were used in providing
3 such medical services.
4 Notwithstanding any other law to the contrary, the Illinois
5 Department shall, within 365 days after July 22, 2013 (the
6 effective date of Public Act 98-104), establish procedures to
7 permit skilled care facilities licensed under the Nursing Home
8 Care Act to submit monthly billing claims for reimbursement
9 purposes. Following development of these procedures, the
10 Department shall, by July 1, 2016, test the viability of the
11 new system and implement any necessary operational or
12 structural changes to its information technology platforms in
13 order to allow for the direct acceptance and payment of nursing
14 home claims.
15 Notwithstanding any other law to the contrary, the Illinois
16 Department shall, within 365 days after August 15, 2014 (the
17 effective date of Public Act 98-963), establish procedures to
18 permit ID/DD facilities licensed under the ID/DD Community Care
19 Act and MC/DD facilities licensed under the MC/DD Act to submit
20 monthly billing claims for reimbursement purposes. Following
21 development of these procedures, the Department shall have an
22 additional 365 days to test the viability of the new system and
23 to ensure that any necessary operational or structural changes
24 to its information technology platforms are implemented.
25 The Illinois Department shall require all dispensers of
26 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, under such terms and conditions as the Illinois Department may by rule establish, all inquiries from clients and attorneys regarding medical bills paid by the Illinois Department, which inquiries could indicate potential existence of claims or liens for the Illinois Department.

Enrollment of a vendor shall be subject to a provisional 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 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

1 adjudication by the primary payer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The period covered by each report shall be the 3 years

1 ending on the June 30 prior to the report. The report shall
2 include suggested legislation for consideration by the General
3 Assembly. The filing of one copy of the report with the
4 Speaker, one copy with the Minority Leader and one copy with
5 the Clerk of the House of Representatives, one copy with the
6 President, one copy with the Minority Leader and one copy with
7 the Secretary of the Senate, one copy with the Legislative
8 Research Unit, and such additional copies with the State
9 Government Report Distribution Center for the General Assembly
10 as is required under paragraph (t) of Section 7 of the State
11 Library Act shall be deemed sufficient to comply with this
12 Section.

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

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

24 Because kidney transplantation can be an appropriate, cost
25 effective alternative to renal dialysis when medically
26 necessary and notwithstanding the provisions of Section 1-11 of

1 this Code, beginning October 1, 2014, the Department shall
2 cover kidney transplantation for noncitizens with end-stage
3 renal disease who are not eligible for comprehensive medical
4 benefits, who meet the residency requirements of Section 5-3 of
5 this Code, and who would otherwise meet the financial
6 requirements of the appropriate class of eligible persons under
7 Section 5-2 of this Code. To qualify for coverage of kidney
8 transplantation, such person must be receiving emergency renal
9 dialysis services covered by the Department. Providers under
10 this Section shall be prior approved and certified by the
11 Department to perform kidney transplantation and the services
12 under this Section shall be limited to services associated with
13 kidney transplantation.

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

25 On or after July 1, 2015, opioid antagonists prescribed for
26 the treatment of an opioid overdose, including the medication

product, administration devices, and any pharmacy fees related to the dispensing and administration of the opioid antagonist, shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article. As used in this Section, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug 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<u>.</u> ~~, 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

1 not accelerate or delay the taking effect of (i) the changes
2 made by this Act or (ii) provisions derived from any other
3 Public Act.

4 Section 99. Effective date. This Act takes effect upon
5 becoming law.".