Rep. Sara Feigenholtz

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1 AMENDMENT TO SENATE BILL 1465

2 AMENDMENT NO. ______. Amend Senate Bill 1465 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The State Employees Group Insurance Act of 1971
5 is amended by changing Sections 6 and 6.1 as follows:

6 (5 ILCS 375/6) (from Ch. 127, par. 526)
7 Sec. 6. Program of health benefits.
8 (a) The program of health benefits shall provide for
9 protection against the financial costs of health care expenses
10 incurred in and out of hospital including basic
11 hospital-surgical-medical coverages. The program may include,
12 but shall not be limited to, such supplemental coverages as
13 out-patient diagnostic X-ray and laboratory expenses,
14 prescription drugs, dental services, hearing evaluations,
15 hearing aids, the dispensing and fitting of hearing aids, and
16 similar group benefits as are now or may become available.

~~However, nothing in this Act shall be construed to permit, on or after July 1, 1980, the non-contributory portion of any such program to include the expenses of obtaining an abortion, induced miscarriage or induced premature birth 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 the unborn child.~~ The program may also include coverage for those who rely on treatment by prayer or spiritual means alone for healing in accordance with the tenets and practice of a recognized religious denomination.

The program of health benefits shall be designed by the Director (1) to provide a reasonable relationship between the benefits to be included and the expected distribution of expenses of each such type to be incurred by the covered members and dependents, (2) to specify, as covered benefits and as optional benefits, the medical services of practitioners in all categories licensed under the Medical Practice Act of 1987, (3) to include reasonable controls, which may include deductible and co-insurance provisions, applicable to some or all of the benefits, or a coordination of benefits provision, to prevent or minimize unnecessary utilization of the various hospital, surgical and medical expenses to be provided and to provide reasonable assurance of stability of the program, and (4) to provide benefits to the extent possible to members

1 throughout the State, wherever located, on an equitable basis.
2 Notwithstanding any other provision of this Section or Act, for
3 all members or dependents who are eligible for benefits under
4 Social Security or the Railroad Retirement system or who had
5 sufficient Medicare-covered government employment, the
6 Department shall reduce benefits which would otherwise be paid
7 by Medicare, by the amount of benefits for which the member or
8 dependents are eligible under Medicare, except that such
9 reduction in benefits shall apply only to those members or
10 dependents who (1) first become eligible for such medicare
11 coverage on or after the effective date of this amendatory Act
12 of 1992; or (2) are Medicare-eligible members or dependents of
13 a local government unit which began participation in the
14 program on or after July 1, 1992; or (3) remain eligible for
15 but no longer receive Medicare coverage which they had been
16 receiving on or after the effective date of this amendatory Act
17 of 1992.
18 Notwithstanding any other provisions of this Act, where a
19 covered member or dependents are eligible for benefits under
20 the federal Medicare health insurance program (Title XVIII of
21 the Social Security Act as added by Public Law 89-97, 89th
22 Congress), benefits paid under the State of Illinois program or
23 plan will be reduced by the amount of benefits paid by
24 Medicare. For members or dependents who are eligible for
25 benefits under Social Security or the Railroad Retirement
26 system or who had sufficient Medicare-covered government

1 employment, benefits shall be reduced by the amount for which
2 the member or dependent is eligible under Medicare, except that
3 such reduction in benefits shall apply only to those members or
4 dependents who (1) first become eligible for such Medicare
5 coverage on or after the effective date of this amendatory Act
6 of 1992; or (2) are Medicare-eligible members or dependents of
7 a local government unit which began participation in the
8 program on or after July 1, 1992; or (3) remain eligible for,
9 but no longer receive Medicare coverage which they had been
10 receiving on or after the effective date of this amendatory Act
11 of 1992. Premiums may be adjusted, where applicable, to an
12 amount deemed by the Director to be reasonably consistent with
13 any reduction of benefits.
14 (b) A member, not otherwise covered by this Act, who has
15 retired as a participating member under Article 2 of the
16 Illinois Pension Code but is ineligible for the retirement
17 annuity under Section 2-119 of the Illinois Pension Code, shall
18 pay the premiums for coverage, not exceeding the amount paid by
19 the State for the non-contributory coverage for other members,
20 under the group health benefits program under this Act. The
21 Director shall determine the premiums to be paid by a member
22 under this subsection (b).
23 (Source: P.A. 93-47, eff. 7-1-03.)

24 (5 ILCS 375/6.1) (from Ch. 127, par. 526.1)
25 Sec. 6.1. The program of health benefits may offer as an

alternative, available on an optional basis, coverage through health maintenance organizations. That part of the premium for such coverage which is in excess of the amount which would otherwise be paid by the State for the program of health benefits shall be paid by the member who elects such alternative coverage and shall be collected as provided for premiums for other optional coverages.

~~However, nothing in this Act shall be construed to permit, after the effective date of this amendatory Act of 1983, the noncontributory portion of any such program to include the expenses of obtaining an abortion, induced miscarriage or induced premature birth 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.~~

(Source: P.A. 85-848.)

Section 10. The Illinois Public Aid Code is amended by changing Sections 5-5, 5-8, 5-9, and 6-1 as follows:

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

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

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

adults; for purposes of this item (13), a uniform screening, assessment, and evaluation process refers to a process that includes an appropriate evaluation and, as warranted, a referral; "uniform" does not mean the use of a singular instrument, tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and 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

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

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

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

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

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

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

1 program. A not-for-profit health clinic shall include a public
2 health clinic or Federally Qualified Health Center or other
3 enrolled provider, as determined by the Department, through
4 which dental services covered under this Section are performed.
5 The Department shall establish a process for payment of claims
6 for reimbursement for covered dental services rendered under
7 this provision.

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

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

18 The Illinois Department shall authorize the provision of,
19 and shall authorize payment for, screening by low-dose
20 mammography for the presence of occult breast cancer for women
21 35 years of age or older who are eligible for medical
22 assistance under this Article, as follows:

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

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

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

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

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

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

26 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.

1 The Department shall work with experts in breast cancer
2 outreach and patient navigation to optimize these reminders and
3 shall establish a methodology for evaluating their
4 effectiveness and modifying the methodology based on the
5 evaluation.
6 The Department shall establish a performance goal for
7 primary care providers with respect to their female patients
8 over age 40 receiving an annual mammogram. This performance
9 goal shall be used to provide additional reimbursement in the
10 form of a quality performance bonus to primary care providers
11 who meet that goal.
12 The Department shall devise a means of case-managing or
13 patient navigation for beneficiaries diagnosed with breast
14 cancer. This program shall initially operate as a pilot program
15 in areas of the State with the highest incidence of mortality
16 related to breast cancer. At least one pilot program site shall
17 be in the metropolitan Chicago area and at least one site shall
18 be outside the metropolitan Chicago area. On or after July 1,
19 2016, the pilot program shall be expanded to include one site
20 in western Illinois, one site in southern Illinois, one site in
21 central Illinois, and 4 sites within metropolitan Chicago. An
22 evaluation of the pilot program shall be carried out measuring
23 health outcomes and cost of care for those served by the pilot
24 program compared to similarly situated patients who are not
25 served by the pilot program.
26 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.

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

The Illinois Department may develop and contract with Partnerships of medical providers to arrange medical services for persons eligible under Section 5-2 of this Code. Implementation of this Section may be by demonstration projects in certain geographic areas. The Partnership shall be

represented by a sponsor organization. The Department, by rule, shall develop qualifications for sponsors of Partnerships. Nothing in this Section shall be construed to require that the sponsor organization be a medical organization.

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

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

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

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

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

1 applicable State law, whichever period is longer, except that
2 if an audit is initiated within the required retention period
3 then the records must be retained until the audit is completed
4 and every exception is resolved. The Illinois Department shall
5 require health care providers to make available, when
6 authorized by the patient, in writing, the medical records in a
7 timely fashion to other health care providers who are treating
8 or serving persons eligible for Medical Assistance under this
9 Article. All dispensers of medical services shall be required
10 to maintain and retain business and professional records
11 sufficient to fully and accurately document the nature, scope,
12 details and receipt of the health care provided to persons
13 eligible for medical assistance under this Code, in accordance
14 with regulations promulgated by the Illinois Department. The
15 rules and regulations shall require that proof of the receipt
16 of prescription drugs, dentures, prosthetic devices and
17 eyeglasses by eligible persons under this Section accompany
18 each claim for reimbursement submitted by the dispenser of such
19 medical services. No such claims for reimbursement shall be
20 approved for payment by the Illinois Department without such
21 proof of receipt, unless the Illinois Department shall have put
22 into effect and shall be operating a system of post-payment
23 audit and review which shall, on a sampling basis, be deemed
24 adequate by the Illinois Department to assure that such drugs,
25 dentures, prosthetic devices and eyeglasses for which payment
26 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), the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

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

1 Notwithstanding any other law to the contrary, the Illinois
2 Department shall, within 365 days after August 15, 2014 (the
3 effective date of Public Act 98-963), establish procedures to
4 permit ID/DD facilities licensed under the ID/DD Community Care
5 Act and MC/DD facilities licensed under the MC/DD Act to submit
6 monthly billing claims for reimbursement purposes. Following
7 development of these procedures, the Department shall have an
8 additional 365 days to test the viability of the new system and
9 to ensure that any necessary operational or structural changes
10 to its information technology platforms are implemented.
11 The Illinois Department shall require all dispensers of
12 medical services, other than an individual practitioner or
13 group of practitioners, desiring to participate in the Medical
14 Assistance program established under this Article to disclose
15 all financial, beneficial, ownership, equity, surety or other
16 interests in any and all firms, corporations, partnerships,
17 associations, business enterprises, joint ventures, agencies,
18 institutions or other legal entities providing any form of
19 health care services in this State under this Article.
20 The Illinois Department may require that all dispensers of
21 medical services desiring to participate in the medical
22 assistance program established under this Article disclose,
23 under such terms and conditions as the Illinois Department may
24 by rule establish, all inquiries from clients and attorneys
25 regarding medical bills paid by the Illinois Department, which
26 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 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

1 timely submittal. Once an admission transaction has been
2 completed, all resubmitted claims following prior rejection
3 are subject to receipt no later than 180 days after the
4 admission transaction has been completed.

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

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

23 The Illinois Department shall enter into agreements with
24 State agencies and departments, and is authorized to enter into
25 agreements with federal agencies and departments, under which
26 such agencies and departments shall share data necessary for

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

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

1 The Illinois Department shall establish policies,
2 procedures, standards and criteria by rule for the acquisition,
3 repair and replacement of orthotic and prosthetic devices and
4 durable medical equipment. Such rules shall provide, but not be
5 limited to, the following services: (1) immediate repair or
6 replacement of such devices by recipients; and (2) rental,
7 lease, purchase or lease-purchase of durable medical equipment
8 in a cost-effective manner, taking into consideration the
9 recipient's medical prognosis, the extent of the recipient's
10 needs, and the requirements and costs for maintaining such
11 equipment. Subject to prior approval, such rules shall enable a
12 recipient to temporarily acquire and use alternative or
13 substitute devices or equipment pending repairs or
14 replacements of any device or equipment previously authorized
15 for such recipient by the Department. Notwithstanding any
16 provision of Section 5-5f to the contrary, the Department may,
17 by rule, exempt certain replacement wheelchair parts from prior
18 approval and, for wheelchairs, wheelchair parts, wheelchair
19 accessories, and related seating and positioning items,
20 determine the wholesale price by methods other than actual
21 acquisition costs.
22 The Department shall require, by rule, all providers of
23 durable medical equipment to be accredited by an accreditation
24 organization approved by the federal Centers for Medicare and
25 Medicaid Services and recognized by the Department in order to
26 bill the Department for providing durable medical equipment to

recipients. No later than 15 months after the effective date of the rule adopted pursuant to this paragraph, all providers must meet the accreditation requirement.

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

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

(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 20 of P.A. 99-588 for the effective date of P.A. 99-407); 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff. 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; revised 9-20-16.)

(305 ILCS 5/5-8) (from Ch. 23, par. 5-8)

Sec. 5-8. Practitioners. In supplying medical assistance, the Illinois Department may provide for the legally authorized services of (i) persons licensed under the Medical Practice Act of 1987, as amended, except as hereafter in this Section stated, whether under a general or limited license, (ii) persons licensed under the Nurse Practice Act as advanced practice nurses, regardless of whether or not the persons have written collaborative agreements, (iii) persons licensed or registered under other laws of this State to provide dental, medical, pharmaceutical, optometric, podiatric, or nursing services, or other remedial care recognized under State law, and (iv) persons licensed under other laws of this State as a clinical social worker. The Department shall adopt rules, no later than 90 days after the effective date of this amendatory Act of the 99th General Assembly, for the legally authorized services of persons licensed under other laws of this State as a clinical social worker. ~~The Department may not provide for legally authorized services of any physician who has been convicted of having performed an abortion procedure in a wilful~~

~~and wanton manner on a woman who was not pregnant at the time such abortion procedure was performed.~~ The utilization of the services of persons engaged in the treatment or care of the sick, which persons are not required to be licensed or registered under the laws of this State, is not prohibited by this Section.

(Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17.)

(305 ILCS 5/5-9) (from Ch. 23, par. 5-9)

Sec. 5-9. Choice of Medical Dispensers. Applicants and recipients shall be entitled to free choice of those qualified practitioners, hospitals, nursing homes, and other dispensers of medical services meeting the requirements and complying with the rules and regulations of the Illinois Department. However, the Director of Healthcare and Family Services may, after providing reasonable notice and opportunity for hearing, deny, suspend or terminate any otherwise qualified person, firm, corporation, association, agency, institution, or other legal entity, from participation as a vendor of goods or services under the medical assistance program authorized by this Article if the Director finds such vendor of medical services in violation of this Act or the policy or rules and regulations issued pursuant to this Act. ~~Any physician who has been convicted 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 shall be automatically~~

~~removed from the list of physicians qualified to participate as a vendor of medical services under the medical assistance program authorized by this Article.~~

(Source: P.A. 95-331, eff. 8-21-07.)

(305 ILCS 5/6-1) (from Ch. 23, par. 6-1)

Sec. 6-1. Eligibility requirements. Financial aid in meeting basic maintenance requirements shall be given under this Article to or in behalf of persons who meet the eligibility conditions of Sections 6-1.1 through 6-1.10. In addition, each unit of local government subject to this Article shall provide persons receiving financial aid in meeting basic maintenance requirements with financial aid for either (a) necessary treatment, care, and supplies required because of illness or disability, or (b) acute medical treatment, care, and supplies only. If a local governmental unit elects to provide financial aid for acute medical treatment, care, and supplies only, the general types of acute medical treatment, care, and supplies for which financial aid is provided shall be specified in the general assistance rules of the local governmental unit, which rules shall provide that financial aid is provided, at a minimum, for acute medical treatment, care, or supplies necessitated by a medical condition for which prior approval or authorization of medical treatment, care, or supplies is not required by the general assistance rules of the Illinois Department. ~~Nothing in this Article shall be construed~~

~~to permit the granting of financial aid where the purpose of such aid is to obtain an abortion, induced miscarriage or induced premature birth 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.~~

(Source: P.A. 92-111, eff. 1-1-02.)

Section 15. The Problem Pregnancy Health Services and Care Act is amended by changing Section 4-100 as follows:

(410 ILCS 230/4-100) (from Ch. 111 1/2, par. 4604-100)

Sec. 4-100. The Department may make grants to nonprofit agencies and organizations ~~which do not use such grants to refer or counsel for, or perform, abortions and~~ which coordinate and establish linkages among services that will further the purposes of this Act and, where appropriate, will provide, supplement, or improve the quality of such services.

(Source: P.A. 83-51.)

Section 20. The Illinois Abortion Law of 1975 is amended by changing Section 1 as follows:

(720 ILCS 510/1) (from Ch. 38, par. 81-21)

Sec. 1. It is the intention of the General Assembly of the State of Illinois to reasonably regulate abortion in conformance with the legal standards set forth in the decisions of the United States Supreme Court of January 22, 1973. ~~Without in any way restricting the right of privacy of a woman or the right of a woman to an abortion under those decisions, the General Assembly of the State of Illinois do solemnly declare and find in reaffirmation of the longstanding policy of this State, that the unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child's right to life and is entitled to the right to life from conception under the laws and Constitution of this State. Further, the General Assembly finds and declares that longstanding policy of this State to protect the right to life of the unborn child from conception by prohibiting abortion unless necessary to preserve the life of the mother is impermissible only because of the decisions of the United States Supreme Court and that, therefore, if those decisions of the United States Supreme Court are ever reversed or modified or the United States Constitution is amended to allow protection of the unborn then the former policy of this State to prohibit abortions unless necessary for the preservation of the mother's life shall be reinstated.~~

~~It is the further intention of the General Assembly to assure and protect the woman's health and the integrity of the woman's decision whether or not to continue to bear a child, to~~

1 ~~protect the valid and compelling state interest in the infant~~
2 ~~and unborn child, to assure the integrity of marital and~~
3 ~~familial relations and the rights and interests of persons who~~
4 ~~participate in such relations, and to gather data for~~
5 ~~establishing criteria for medical decisions. The General~~
6 ~~Assembly finds as fact, upon hearings and public disclosures,~~
7 ~~that these rights and interests are not secure in the economic~~
8 ~~and social context in which abortion is presently performed.~~
9 (Source: P.A. 81-1078.)".