SB1844

LRB104 10157 KTG 20229 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB1844

Introduced 2/5/2025, by Sen. Sara Feigenholtz

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5.12f

Amends the Medical Assistance Article of the Illinois Public Aid Code. In a provision prohibiting prior authorization mandates and utilization management controls under the fee-for-service and managed care medical assistance programs for FDA-approved prescription drugs that treat mental illness, requires the Department of Healthcare and Family Services and managed care organizations to report quarterly on compliance with the specified prohibitions beginning with dates of service on and after July 1, 2025. Requires the Department to post on its website a report on fee-for-service prescriptions and the reports from each managed care organization. Sets forth the information that must be contained in the quarterly reports, including, but not limited to: (i) the number of denied prescriptions and estimated net cost to the State for those covered prescriptions summarized by each of the allowed categories specified in the Code; (ii) the number of denied prescriptions and estimated net cost to the State for those prescriptions summarized by each of the non-allowed categories specified in the Code; and (iii) the number of denied prescriptions and estimated gross cost to the State for those prescriptions summarized by any other reason not specified in the Code. Requires the Department to sanction those managed care organizations that do not file the required reports. Effective immediately.

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A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Section 5-5.12f as follows:

(305 ILCS 5/5-5.12f)

Sec. 5-5.12f. Prescription drugs for mental illness; no utilization or prior approval mandates.

(a) Notwithstanding any other provision of this Code to the contrary, except as otherwise provided in subsection (b), for the purpose of removing barriers to the timely treatment of serious mental illnesses, prior authorization mandates and utilization management controls shall not be imposed under the fee-for-service and managed care medical assistance programs on any FDA-approved prescription drug that is recognized by a generally accepted standard medical reference as effective in the treatment of conditions specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association if a preferred or non-preferred drug is prescribed to an adult patient to treat serious mental illness and one of the following applies:

(1) the patient has changed providers, including, but

not limited to, a change from an inpatient to an outpatient provider, and is stable on the drug that has been previously prescribed, and received prior authorization, if required;

(2) the patient has changed insurance coverage and is stable on the drug that has been previously prescribed and received prior authorization under the previous source of coverage; or

(3) subject to federal law on maximum dosage limits and safety edits adopted by the Department's Drug and Therapeutics Board, including those safety edits and limits needed to comply with federal requirements contained in 42 CFR 456.703, the patient has previously been prescribed and obtained prior authorization for the drug and the prescription modifies the dosage, dosage frequency, or both, of the drug as part of the same treatment for which the drug was previously prescribed.

(b) The following safety edits shall be permitted for prescription drugs covered under this Section:

(1) clinically appropriate drug utilization review (DUR) edits, including, but not limited to, drug-to-drug, drug-age, and drug-dose;

(2) generic drug substitution if a generic drug is available for the prescribed medication in the same dosage and formulation; and

(3) any utilization management control that is

necessary for the Department to comply with any current consent decrees or federal waivers.

(c) As used in this Section, "serious mental illness" means any one or more of the following diagnoses and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes listed by the Department of Human Services' Division of Mental Health, as amended, on its official website:

(1) Delusional Disorder (F22)

(2) Brief Psychotic Disorder (F23)

(3) Schizophreniform Disorder (F20.81)

(4) Schizophrenia (F20.9)

(5) Schizoaffective Disorder (F25.x)

(6) Catatonia Associated with Another Mental Disorder (Catatonia Specifier) (F06.1)

(7) Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (F28)

(8) Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (F29)

(9) Bipolar I Disorder (F31.xx)

(10) Bipolar II Disorder (F31.81)

(11) Cyclothymic Disorder (F34.0)

(12) Unspecified Bipolar and Related Disorder (F31.9)

(13) Disruptive Mood Dysregulation Disorder (F34.8)

(14) Major Depressive Disorder Single episode (F32.xx)

(15) Major Depressive Disorder, Recurrent episode

(F33.xx)

(16) Obsessive-Compulsive Disorder (F42)

(17) Posttraumatic Stress Disorder (F43.10)

(18) Anorexia Nervosa (F50.0x)

(19) Bulimia Nervosa (F50.2)

(20) Postpartum Depression (F53.0)

(21) Puerperal Psychosis (F53.1)

(22) Factitious Disorder Imposed on Another (F68.A)

(d) Notwithstanding any other provision of law, nothing in this Section shall not be construed to conflict with Section 1927(a)(1) and (b)(1)(A) of the federal Social Security Act and any implementing regulations and agreements.

(e) The Department and all managed care organizations are required to report quarterly on compliance with the conditions of this Section beginning with dates of service on and after July 1, 2025. Reports are due 60 calendar days after the end of the quarter to be reported. For example, for dates of services occurring in the quarter ending September 30, 2025, reports are due November 29, 2025. The Department may delay the due date until the next business day if it falls on a State-recognized holiday or a weekend. The Department must post on its website a report on fee-for-service prescriptions and the reports from each managed care organization. For all prescription drugs described in subsection (a), the following information must be reported:

(1) The number of denied prescriptions and estimated

net cost to the State for those prescriptions summarized by each of the allowed categories specified in subsection (b). This paragraph shall include the number of prior authorization denials and step therapy exception requests.

(2) The number of denied prescriptions and estimated net cost to the State for those prescriptions summarized by each of the non-allowed categories specified in subsection (a). This paragraph shall include the number of prior authorization denials and step therapy exception requests.

(3) The number of denied prescriptions and estimated gross cost to the State for those prescriptions summarized by any other reason not specified in subsection (a) or (b). This paragraph shall include the number of prior authorization denials, step therapy exception requests, number of step edits for each medication, and any rebate revenue associated with those prescriptions.

(4) The number of approved and paid prescriptions and net cost to the State for those prescriptions summarized by any other reason not specified in subsection (a) or (b). This paragraph shall include the number of prior authorization denials, step therapy exception requests, number of step edits for each medication, and any rebate revenue associated with those prescriptions.

(5) The number of complaints filed concerning denials for prescriptions which meet the conditions specified in

subsection (a). This paragraph shall include the number of prior authorization denials and step therapy exception requests.

(6) The number of people using emergency room services based on categories specified in subsection (c).

(7) The number of people who are admitted into the hospital and hospital readmissions (7 or 30 days post release) based on categories specified in subsection (c) and the cost of care while receiving treatment.

The Department shall sanction managed care organizations that do not file reports mandated by this subsection.

(Source: P.A. 103-593, eff. 6-7-24.)

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