Sen. Cristina Castro

Filed: 4/5/2019

1 AMENDMENT TO SENATE BILL 1909

2 AMENDMENT NO. ______. Amend Senate Bill 1909, AS AMENDED,
3 by replacing everything after the enacting clause with the
4 following:

5 "Section 1. This Act may be referred to as the Improving
6 Health Care for Pregnant and Postpartum Individuals Act.

7 Section 5. The State Employees Group Insurance Act of 1971
8 is amended by changing Section 6.11 as follows:

9 (5 ILCS 375/6.11)
10 (Text of Section before amendment by P.A. 100-1170)
11 Sec. 6.11. Required health benefits; Illinois Insurance
12 Code requirements. The program of health benefits shall provide
13 the post-mastectomy care benefits required to be covered by a
14 policy of accident and health insurance under Section 356t of
15 the Illinois Insurance Code. The program of health benefits

1 shall provide the coverage required under Sections 356g,
2 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4,
3 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
4 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, ~~and~~ 356z.26, ~~and~~
5 356z.29, 356z.32, and 356z.33 of the Illinois Insurance Code.
6 The program of health benefits must comply with Sections
7 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 of the
8 Illinois Insurance Code. The Department of Insurance shall
9 enforce the requirements of this Section.
10 Rulemaking authority to implement Public Act 95-1045, if
11 any, is conditioned on the rules being adopted in accordance
12 with all provisions of the Illinois Administrative Procedure
13 Act and all rules and procedures of the Joint Committee on
14 Administrative Rules; any purported rule not so adopted, for
15 whatever reason, is unauthorized.
16 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
17 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff.
18 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised
19 1-8-19.)

20 (Text of Section after amendment by P.A. 100-1170)
21 Sec. 6.11. Required health benefits; Illinois Insurance
22 Code requirements. The program of health benefits shall provide
23 the post-mastectomy care benefits required to be covered by a
24 policy of accident and health insurance under Section 356t of
25 the Illinois Insurance Code. The program of health benefits

shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, ~~and~~ 356z.32, and 356z.33 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 of the Illinois Insurance Code; all other requirements of this Section shall be enforced by the Department of Central Management Services.

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.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 100-1170, eff. 6-1-19.)

Section 10. The Department of Human Services Act is amended by adding Sections 10-23 and 10-24 as follows:

1 (20 ILCS 1305/10-23 new)
2 Sec. 10-23. High-risk pregnant or postpartum women. The
3 Department shall expand and update its maternal child health
4 programs to serve any pregnant or postpartum woman identified
5 as high-risk by her primary care provider or hospital according
6 to standards developed by the Department of Public Health under
7 Section 3 of the Developmental Disability Prevention Act. The
8 services shall be provided by registered nurses, licensed
9 social workers, or other staff with behavioral health or
10 medical training, as approved by the Department. The persons
11 providing the services may collaborate with other providers,
12 including, but not limited to, obstetricians, gynecologists,
13 or pediatricians, when providing services to a patient.

14 (20 ILCS 1305/10-24 new)
15 Sec. 10-24. Nurse-Family Partnership Pilot Program.
16 Subject to the availability of funds provided for this purpose
17 by public or private sources, the Department may, in its
18 discretion, establish an evidence-based, voluntary, nurse home
19 visitation program that improves the health and well-being of
20 low-income, first-time pregnant women and their children. The
21 program shall be known as the Nurse-Family Partnership Pilot
22 Program and shall include, but not be limited to, the following
23 components:
24 (1) Eligibility criteria. Program participants must be
25 first-time pregnant women who have yet to reach the 28th

1 week of pregnancy and who are eligible for medical
2 assistance under Article V of the Illinois Public Aid Code.
3 (2) Maternal health education. Registered nurses shall
4 make home visits to program participants and shall provide
5 education, support, and guidance regarding pregnancy and
6 maternal health, child health and development, parenting,
7 the mother's life course development, and instruction on
8 how to identify and use family and community supports.
9 (3) Pre-natal and post-natal care. Home visits to
10 program participants shall begin before their 28th week of
11 pregnancy and shall continue on a weekly or biweekly basis
12 until their children reach the age of 2.

13 Section 15. The Department of Public Health Powers and
14 Duties Law of the Civil Administrative Code of Illinois is
15 amended by adding Section 2310-455 as follows:

16 (20 ILCS 2310/2310-455 new)
17 Sec. 2310-455. High Risk Infant Follow-up. The Department,
18 in collaboration with the Department of Human Services, the
19 Department of Healthcare and Family Services, and other key
20 providers of maternal child health services, shall revise or
21 add to the rules of the Maternal and Child Health Services Code
22 (77 Ill. Adm. Code 630) that govern the High Risk Infant
23 Follow-up, using current scientific and national and State
24 outcomes data, to expand existing services to improve both

1 maternal and infant outcomes overall and to reduce racial
2 disparities in outcomes and services provided. The rules shall
3 be revised or adopted on or before June 1, 2021.

4 Section 20. The Counties Code is amended by changing
5 Section 5-1069.3 as follows:

6 (55 ILCS 5/5-1069.3)
7 Sec. 5-1069.3. Required health benefits. If a county,
8 including a home rule county, is a self-insurer for purposes of
9 providing health insurance coverage for its employees, the
10 coverage shall include coverage for the post-mastectomy care
11 benefits required to be covered by a policy of accident and
12 health insurance under Section 356t and the coverage required
13 under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x,
14 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
15 356z.14, 356z.15, 356z.22, 356z.25, ~~and~~ 356z.26, ~~and~~ 356z.29,
16 356z.32, and 356z.33 of the Illinois Insurance Code. The
17 coverage shall comply with Sections 155.22a, 355b, 356z.19, and
18 370c of the Illinois Insurance Code. The Department of
19 Insurance shall enforce the requirements of this Section. The
20 requirement that health benefits be covered as provided in this
21 Section is an exclusive power and function of the State and is
22 a denial and limitation under Article VII, Section 6,
23 subsection (h) of the Illinois Constitution. A home rule county
24 to which this Section applies must comply with every provision

of 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.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 10-3-18.)

Section 25. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, ~~and~~ 356z.26, ~~and~~ 356z.29<u>, 356z.32, and 356z.33</u> of the Illinois

1 Insurance Code. The coverage shall comply with Sections
2 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance
3 Code. The Department of Insurance shall enforce the
4 requirements of this Section. The requirement that health
5 benefits be covered as provided in this is an exclusive power
6 and function of the State and is a denial and limitation under
7 Article VII, Section 6, subsection (h) of the Illinois
8 Constitution. A home rule municipality to which this Section
9 applies must comply with every provision of this Section.

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

16 (Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17;
17 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff.
18 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised
19 10-4-18.)

20 Section 30. The School Code is amended by changing Section
21 10-22.3f as follows:

22 (105 ILCS 5/10-22.3f)

23 Sec. 10-22.3f. Required health benefits. Insurance
24 protection and benefits for employees shall provide the

1 post-mastectomy care benefits required to be covered by a
2 policy of accident and health insurance under Section 356t and
3 the coverage required under Sections 356g, 356g.5, 356g.5-1,
4 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12,
5 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, ~~and~~ 356z.26, ~~and~~
6 356z.29, 356z.32, and 356z.33 of the Illinois Insurance Code.
7 Insurance policies shall comply with Section 356z.19 of the
8 Illinois Insurance Code. The coverage shall comply with
9 Sections 155.22a, 355b, and 370c of the Illinois Insurance
10 Code. The Department of Insurance shall enforce the
11 requirements of this Section.

12 Rulemaking authority to implement Public Act 95-1045, if
13 any, is conditioned on the rules being adopted in accordance
14 with all provisions of the Illinois Administrative Procedure
15 Act and all rules and procedures of the Joint Committee on
16 Administrative Rules; any purported rule not so adopted, for
17 whatever reason, is unauthorized.
18 (Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
19 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff.
20 1-1-19; 100-1102, eff. 1-1-19; revised 10-4-18.)

21 Section 35. The Illinois Insurance Code is amended by
22 adding Sections 356z.4a and 356z.33 as follows:

23 (215 ILCS 5/356z.4a new)
24 Sec. 356z.4a. Billing for long-acting reversible

1 contraceptives.
2 (a) "Long-acting reversible contraceptive device" means
3 any intrauterine device or contraceptive implant.
4 (b) Any group health insurance policy, individual health
5 policy, group policy of accident and health insurance, group
6 health benefit plan, or qualified health plan that is offered
7 through the health insurance marketplace, a small employer
8 group health plan, or a large employer group health plan that
9 is amended, delivered, issued, or renewed on or after the
10 effective date of this amendatory Act of the 101st General
11 Assembly shall allow hospitals separate reimbursement for a
12 long-acting reversible contraceptive device provided
13 immediately postpartum in the inpatient hospital setting
14 before hospital discharge. The payment shall be made in
15 addition to a bundled or Diagnostic Related Group reimbursement
16 for labor and delivery.

17 (215 ILCS 5/356z.33 new)
18 Sec. 356z.33. Pregnancy and postpartum coverage.
19 (a) A group health insurance policy, individual health
20 policy, group policy of accident and health insurance, group
21 health benefit plan, qualified health plan that is offered
22 through the health insurance marketplace, small employer group
23 health plan, or large employer group health plan that is
24 amended, delivered, issued, or renewed on or after the
25 effective date of this amendatory Act of the 101st General

1 Assembly shall provide coverage for medically necessary
2 treatment for postpartum complications, including, but not
3 limited to, infection, depression, and hemorrhaging, up to one
4 year after the woman has given birth to a child as set forth in
5 this Section and consistent with other Sections of this Code,
6 including, but not limited to, Sections 370c and 370c.1. The
7 coverage under this Section shall be subject to other general
8 exclusions, limitations, and financial requirements of the
9 policy, including coordination of benefits, participating
10 provider requirements, and utilization review of health care
11 services, including review of medical necessity, case
12 management, experimental and investigational treatments,
13 managed care provisions, and other terms and conditions.
14 (b) A group health insurance policy, individual health
15 policy, group policy of accident and health insurance, group
16 health benefit plan, qualified health plan that is offered
17 through the health insurance marketplace, small employer group
18 health plan, or large employer group health plan that is
19 amended, delivered, issued, or renewed on or after the
20 effective date of this amendatory Act of the 101st General
21 Assembly shall provide coverage for medically necessary
22 treatment of mental, emotional, nervous, or substance use
23 disorder or conditions at in-network facilities for a pregnant
24 or postpartum woman up to one year after giving birth to a
25 child consistent with the requirements set forth in this
26 Section and in Sections 370c and 370c.1 of this Code. The

services for the treatment of mental, emotional, nervous, or substance use disorder or condition shall be prescribed or ordered by a licensed physician, licensed psychologist, licensed psychiatrist, or licensed advanced practice registered nurse and provided by licensed health care professionals or licensed or certified mental, emotional, nervous, or substance use disorder or conditions providers in licensed, certified, or otherwise State-approved facilities.

As used in this subsection (b), "provider" includes licensed physicians, licensed psychologists, licensed psychiatrists, licensed advanced practice registered nurses, and licensed and certified mental, emotional, nervous, and substance use disorder and conditions providers.

Benefits under this subsection (b) shall be as follows:

(1) The benefits provided for inpatient and outpatient services for the treatment of mental, emotional, nervous, or substance use disorder or conditions related to pregnancy or postpartum complications shall be provided when determined to be medically necessary consistent with the requirements of Sections 370c and 370c.1 of this Code. The facility or provider shall notify the insurer of both the admission and the initial treatment plan within 48 hours after admission or initiation of treatment. Nothing shall prevent an insurer from applying concurrent and post-service utilization review of health care services, including review of medical necessity, case management,

1 experimental and investigational treatments, managed care
2 provisions, and other terms and conditions of the insurance
3 policy.
4 (2) The benefits for the first 48 hours of initiation
5 of services for an inpatient admission,
6 detoxification/withdrawal management program, or a partial
7 hospitalization admission for the treatment of mental,
8 emotional, nervous, or substance use disorder or
9 conditions related to pregnancy or postpartum
10 complications shall be provided without post-service or
11 concurrent review of medical necessity, as the medical
12 necessity for the first 48 hours of such services shall be
13 determined solely by the covered pregnant or postpartum
14 woman's provider. Nothing shall prevent an insurer from
15 applying concurrent and post-service utilization review,
16 including the review of medical necessity, case
17 management, experimental and investigational treatments,
18 managed care provisions, and other terms and conditions of
19 the insurance policy of any inpatient admission,
20 detoxification/withdrawal management program admission, or
21 a partial hospitalization admission services for the
22 treatment of mental emotional, nervous, or substance use
23 disorder or conditions related to pregnancy or postpartum
24 complications received 48 hours after the initiation of
25 such services. If an insurer determines that the services
26 are no longer medically necessary, then the covered person

1 shall have the right to external review pursuant to the
2 requirements of the Health Carrier External Review Act.
3 (3) If an insurer determines that continued inpatient
4 care, detoxification/withdrawal management, partial
5 hospitalization, intensive outpatient treatment, or
6 outpatient treatment in a facility is no longer medically
7 necessary, the insurer shall, within 24 hours, provide
8 written notice to the covered pregnant or postpartum woman
9 and the covered pregnant or postpartum woman's provider of
10 its decision and the right to file an expedited internal
11 appeal of the determination. The insurer shall review and
12 make a determination with respect to the internal appeal
13 within 24 hours and communicate such determination to the
14 covered pregnant or postpartum woman and the covered
15 pregnant or postpartum woman's provider. If the
16 determination is to uphold the denial, the covered pregnant
17 or postpartum woman and the covered pregnant or postpartum
18 woman's provider have the right to file an expedited
19 external appeal. An independent utilization review
20 organization shall make a determination within 72 hours. If
21 the insurer's determination is upheld and it is determined
22 continued inpatient care, detoxification/withdrawal
23 management, partial hospitalization, intensive outpatient
24 treatment, or outpatient treatment is not medically
25 necessary, the insurer shall remain responsible to provide
26 benefits for the inpatient care, detoxification/withdrawal

1 management, partial hospitalization, intensive outpatient
2 treatment, or outpatient treatment through the day
3 following the date the determination is made and the
4 covered pregnant or postpartum woman shall only be
5 responsible for any applicable copayment, deductible, and
6 coinsurance for the stay through that date as applicable
7 under the policy. The covered pregnant or postpartum woman
8 shall not be discharged or released from the inpatient
9 facility, detoxification/withdrawal management, partial
10 hospitalization, intensive outpatient treatment, or
11 outpatient treatment until all internal appeals and
12 independent utilization review organization appeals are
13 exhausted. A decision to reverse an adverse determination
14 shall comply with the Health Carrier External Review Act.
15 (4) Except as otherwise stated in this subsection (b),
16 the benefits and cost-sharing shall be provided to the same
17 extent as for any other medical condition covered under the
18 policy.
19 (5) The benefits required by this subsection (b) are to
20 be provided to all covered pregnant or postpartum woman
21 with a diagnosis of mental, emotional, nervous, or
22 substance use disorder or conditions. The presence of
23 additional related or unrelated diagnoses shall not be a
24 basis to reduce or deny the benefits required by this
25 subsection (b).
26 (c) A group health insurance policy, individual health

1 policy, group policy of accident and health insurance, group
2 health benefit plan, qualified health plan that is offered
3 through the health insurance marketplace, small employer group
4 health plan, or large employer group health plan that is
5 amended, delivered, issued, executed, or renewed in this State
6 or approved for issuance or renewal in this State on or after
7 the effective date of this amendatory Act of the 101st General
8 Assembly shall provide coverage for case management and
9 outreach for a postpartum woman that had a high-risk pregnancy.
10 The coverage under this subsection (c) shall take into
11 consideration the cultural differences of the covered
12 postpartum woman in case coordination. As used in this
13 subsection (c), "high-risk pregnancy" means a pregnancy in
14 which the mother or baby is at increased risk for poor health
15 or complications during pregnancy or childbirth.

16 Section 40. The Health Maintenance Organization Act is
17 amended by changing Section 5-3 as follows:

18 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)
19 Sec. 5-3. Insurance Code provisions.
20 (a) Health Maintenance Organizations shall be subject to
21 the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1,
22 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154,
23 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3,
24 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4,

356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to

the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be

1 acquired for a period of not less than 3 years; and
2 (D) such other information as the Director shall
3 require.
4 (d) The provisions of Article VIII 1/2 of the Illinois
5 Insurance Code and this Section 5-3 shall apply to the sale by
6 any health maintenance organization of greater than 10% of its
7 enrollee population (including without limitation the health
8 maintenance organization's right, title, and interest in and to
9 its health care certificates).
10 (e) In considering any management contract or service
11 agreement subject to Section 141.1 of the Illinois Insurance
12 Code, the Director (i) shall, in addition to the criteria
13 specified in Section 141.2 of the Illinois Insurance Code, take
14 into account the effect of the management contract or service
15 agreement on the continuation of benefits to enrollees and the
16 financial condition of the health maintenance organization to
17 be managed or serviced, and (ii) need not take into account the
18 effect of the management contract or service agreement on
19 competition.
20 (f) Except for small employer groups as defined in the
21 Small Employer Rating, Renewability and Portability Health
22 Insurance Act and except for medicare supplement policies as
23 defined in Section 363 of the Illinois Insurance Code, a Health
24 Maintenance Organization may by contract agree with a group or
25 other enrollment unit to effect refunds or charge additional
26 premiums under the following terms and conditions:

1 (i) the amount of, and other terms and conditions with
2 respect to, the refund or additional premium are set forth
3 in the group or enrollment unit contract agreed in advance
4 of the period for which a refund is to be paid or
5 additional premium is to be charged (which period shall not
6 be less than one year); and
7 (ii) the amount of the refund or additional premium
8 shall not exceed 20% of the Health Maintenance
9 Organization's profitable or unprofitable experience with
10 respect to the group or other enrollment unit for the
11 period (and, for purposes of a refund or additional
12 premium, the profitable or unprofitable experience shall
13 be calculated taking into account a pro rata share of the
14 Health Maintenance Organization's administrative and
15 marketing expenses, but shall not include any refund to be
16 made or additional premium to be paid pursuant to this
17 subsection (f)). The Health Maintenance Organization and
18 the group or enrollment unit may agree that the profitable
19 or unprofitable experience may be calculated taking into
20 account the refund period and the immediately preceding 2
21 plan years.
22 The Health Maintenance Organization shall include a
23 statement in the evidence of coverage issued to each enrollee
24 describing the possibility of a refund or additional premium,
25 and upon request of any group or enrollment unit, provide to
26 the group or enrollment unit a description of the method used

to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) 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.

(Source: P.A. 99-761, eff. 1-1-18; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 10-4-18.)

Section 45. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 356g, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

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.

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 10-4-18.)

Section 50. The Illinois Public Aid Code is amended by changing Sections 5-2, 5-5, and 5-5.24 and by adding Section 5-5.27 as follows:

1 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)
2 Sec. 5-2. Classes of Persons Eligible.
3 Medical assistance under this Article shall be available to
4 any of the following classes of persons in respect to whom a
5 plan for coverage has been submitted to the Governor by the
6 Illinois Department and approved by him. If changes made in
7 this Section 5-2 require federal approval, they shall not take
8 effect until such approval has been received:
9 1. Recipients of basic maintenance grants under
10 Articles III and IV.
11 2. Beginning January 1, 2014, persons otherwise
12 eligible for basic maintenance under Article III,
13 excluding any eligibility requirements that are
14 inconsistent with any federal law or federal regulation, as
15 interpreted by the U.S. Department of Health and Human
16 Services, but who fail to qualify thereunder on the basis
17 of need, and who have insufficient income and resources to
18 meet the costs of necessary medical care, including but not
19 limited to the following:
20 (a) All persons otherwise eligible for basic
21 maintenance under Article III but who fail to qualify
22 under that Article on the basis of need and who meet
23 either of the following requirements:
24 (i) their income, as determined by the
25 Illinois Department in accordance with any federal
26 requirements, is equal to or less than 100% of the

federal poverty level; or

(ii) their income, after the deduction of costs incurred for medical care and for other types of remedial care, is equal to or less than 100% of the federal poverty level.

(b) (Blank).

3. (Blank).

4. Persons not eligible under any of the preceding paragraphs who fall sick, are injured, or die, not having sufficient money, property or other resources to meet the costs of necessary medical care or funeral and burial expenses.

5.(a) Women during pregnancy and during the <u>12-month</u> ~~60-day~~ period beginning on the last day of the pregnancy, together with their infants, whose income is at or below 200% of the federal poverty level. Until September 30, 2019, or sooner if the maintenance of effort requirements under the Patient Protection and Affordable Care Act are eliminated or may be waived before then, women during pregnancy and during the <u>12-month</u> ~~60-day~~ period beginning on the last day of the pregnancy, whose countable monthly income, after the deduction of costs incurred for medical care and for other types of remedial care as specified in administrative rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1, 2013 as set forth in administrative rule.

1 (b) The plan for coverage shall provide ambulatory
2 prenatal care to pregnant women during a presumptive
3 eligibility period and establish an income eligibility
4 standard that is equal to 200% of the federal poverty
5 level, provided that costs incurred for medical care are
6 not taken into account in determining such income
7 eligibility.
8 (c) The Illinois Department may conduct a
9 demonstration in at least one county that will provide
10 medical assistance to pregnant women, together with their
11 infants and children up to one year of age, where the
12 income eligibility standard is set up to 185% of the
13 nonfarm income official poverty line, as defined by the
14 federal Office of Management and Budget. The Illinois
15 Department shall seek and obtain necessary authorization
16 provided under federal law to implement such a
17 demonstration. Such demonstration may establish resource
18 standards that are not more restrictive than those
19 established under Article IV of this Code.
20 6. (a) Children younger than age 19 when countable
21 income is at or below 133% of the federal poverty level.
22 Until September 30, 2019, or sooner if the maintenance of
23 effort requirements under the Patient Protection and
24 Affordable Care Act are eliminated or may be waived before
25 then, children younger than age 19 whose countable monthly
26 income, after the deduction of costs incurred for medical

care and for other types of remedial care as specified in administrative rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1, 2013 as set forth in administrative rule.

(b) Children and youth who are under temporary custody or guardianship of the Department of Children and Family Services or who receive financial assistance in support of an adoption or guardianship placement from the Department of Children and Family Services.

7. (Blank).

8. As required under federal law, persons who are eligible for Transitional Medical Assistance as a result of an increase in earnings or child or spousal support received. The plan for coverage for this class of persons shall:

(a) extend the medical assistance coverage to the extent required by federal law; and

(b) offer persons who have initially received 6 months of the coverage provided in paragraph (a) above, the option of receiving an additional 6 months of coverage, subject to the following:

(i) such coverage shall be pursuant to provisions of the federal Social Security Act;

(ii) such coverage shall include all services covered under Illinois' State Medicaid Plan;

(iii) no premium shall be charged for such

coverage; and

(iv) such coverage shall be suspended in the event of a person's failure without good cause to file in a timely fashion reports required for this coverage under the Social Security Act and coverage shall be reinstated upon the filing of such reports if the person remains otherwise eligible.

9. Persons with acquired immunodeficiency syndrome (AIDS) or with AIDS-related conditions with respect to whom there has been a determination that but for home or community-based services such individuals would require the level of care provided in an inpatient hospital, skilled nursing facility or intermediate care facility the cost of which is reimbursed under this Article. Assistance shall be provided to such persons to the maximum extent permitted under Title XIX of the Federal Social Security Act.

10. Participants in the long-term care insurance partnership program established under the Illinois Long-Term Care Partnership Program Act who meet the qualifications for protection of resources described in Section 15 of that Act.

11. Persons with disabilities who are employed and eligible for Medicaid, pursuant to Section 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,

1 subject to federal approval, persons with a medically
2 improved disability who are employed and eligible for
3 Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of
4 the Social Security Act, as provided by the Illinois
5 Department by rule. In establishing eligibility standards
6 under this paragraph 11, the Department shall, subject to
7 federal approval:
8 (a) set the income eligibility standard at not
9 lower than 350% of the federal poverty level;
10 (b) exempt retirement accounts that the person
11 cannot access without penalty before the age of 59 1/2,
12 and medical savings accounts established pursuant to
13 26 U.S.C. 220;
14 (c) allow non-exempt assets up to $25,000 as to
15 those assets accumulated during periods of eligibility
16 under this paragraph 11; and
17 (d) continue to apply subparagraphs (b) and (c) in
18 determining the eligibility of the person under this
19 Article even if the person loses eligibility under this
20 paragraph 11.
21 12. Subject to federal approval, persons who are
22 eligible for medical assistance coverage under applicable
23 provisions of the federal Social Security Act and the
24 federal Breast and Cervical Cancer Prevention and
25 Treatment Act of 2000. Those eligible persons are defined
26 to include, but not be limited to, the following persons:

(1) persons who have been screened for breast or cervical cancer under the U.S. Centers for Disease Control and Prevention Breast and Cervical Cancer Program established under Title XV of the federal Public Health Services Act in accordance with the requirements of Section 1504 of that Act as administered by the Illinois Department of Public Health; and

(2) persons whose screenings under the above program were funded in whole or in part by funds appropriated to the Illinois Department of Public Health for breast or cervical cancer screening.

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the coverage under this paragraph 12 within 30 days after the effective date of this amendatory Act of the 92nd General Assembly.

In addition to the persons who are eligible for medical assistance pursuant to subparagraphs (1) and (2) of this paragraph 12, and to be paid from funds appropriated to the Department for its medical programs, any uninsured person as defined by the Department in rules residing in Illinois who is younger than 65 years of age, who has been screened for breast and cervical cancer in accordance with standards

1 and procedures adopted by the Department of Public Health
2 for screening, and who is referred to the Department by the
3 Department of Public Health as being in need of treatment
4 for breast or cervical cancer is eligible for medical
5 assistance benefits that are consistent with the benefits
6 provided to those persons described in subparagraphs (1)
7 and (2). Medical assistance coverage for the persons who
8 are eligible under the preceding sentence is not dependent
9 on federal approval, but federal moneys may be used to pay
10 for services provided under that coverage upon federal
11 approval.

12 13. Subject to appropriation and to federal approval,
13 persons living with HIV/AIDS who are not otherwise eligible
14 under this Article and who qualify for services covered
15 under Section 5-5.04 as provided by the Illinois Department
16 by rule.

17 14. Subject to the availability of funds for this
18 purpose, the Department may provide coverage under this
19 Article to persons who reside in Illinois who are not
20 eligible under any of the preceding paragraphs and who meet
21 the income guidelines of paragraph 2(a) of this Section and
22 (i) have an application for asylum pending before the
23 federal Department of Homeland Security or on appeal before
24 a court of competent jurisdiction and are represented
25 either by counsel or by an advocate accredited by the
26 federal Department of Homeland Security and employed by a

not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

(a) On and after July 1, 2012, a parent or other caretaker relative who is 19 years of age or older when countable income is at or below 133% of the federal poverty level. A person may not spend down to become eligible under this paragraph 15.

(b) Eligibility shall be reviewed annually.

(c) (Blank).

(d) (Blank).

(e) (Blank).

(f) (Blank).

(g) (Blank).

(h) (Blank).

(i) Following termination of an individual's

coverage under this paragraph 15, the individual must be determined eligible before the person can be re-enrolled.

16. Subject to appropriation, uninsured persons who are not otherwise eligible under this Section who have been certified and referred by the Department of Public Health as having been screened and found to need diagnostic evaluation or treatment, or both diagnostic evaluation and treatment, for prostate or testicular cancer. For the purposes of this paragraph 16, uninsured persons are those who do not have creditable coverage, as defined under the Health Insurance Portability and Accountability Act, or have otherwise exhausted any insurance benefits they may have had, for prostate or testicular cancer diagnostic evaluation or treatment, or both diagnostic evaluation and treatment. To be eligible, a person must furnish a Social Security number. A person's assets are exempt from consideration in determining eligibility under this paragraph 16. Such persons shall be eligible for medical assistance under this paragraph 16 for so long as they need treatment for the cancer. A person shall be considered to need treatment if, in the opinion of the person's treating physician, the person requires therapy directed toward cure or palliation of prostate or testicular cancer, including recurrent metastatic cancer that is a known or presumed complication of prostate or testicular cancer and

complications resulting from the treatment modalities themselves. Persons who require only routine monitoring services are not considered to need treatment. "Medical assistance" under this paragraph 16 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. Notwithstanding any other provision of law, the Department (i) does not have a claim against the estate of a deceased recipient of services under this paragraph 16 and (ii) does not have a lien against any homestead property or other legal or equitable real property interest owned by a recipient of services under this paragraph 16.

17. Persons who, pursuant to a waiver approved by the Secretary of the U.S. Department of Health and Human Services, are eligible for medical assistance under Title XIX or XXI of the federal Social Security Act. Notwithstanding any other provision of this Code and consistent with the terms of the approved waiver, the Illinois Department, may by rule:

(a) Limit the geographic areas in which the waiver program operates.

(b) Determine the scope, quantity, duration, and quality, and the rate and method of reimbursement, of the medical services to be provided, which may differ from those for other classes of persons eligible for assistance under this Article.

1 (c) Restrict the persons' freedom in choice of
2 providers.
3 18. Beginning January 1, 2014, persons aged 19 or
4 older, but younger than 65, who are not otherwise eligible
5 for medical assistance under this Section 5-2, who qualify
6 for medical assistance pursuant to 42 U.S.C.
7 1396a(a)(10)(A)(i)(VIII) and applicable federal
8 regulations, and who have income at or below 133% of the
9 federal poverty level plus 5% for the applicable family
10 size as determined pursuant to 42 U.S.C. 1396a(e)(14) and
11 applicable federal regulations. Persons eligible for
12 medical assistance under this paragraph 18 shall receive
13 coverage for the Health Benefits Service Package as that
14 term is defined in subsection (m) of Section 5-1.1 of this
15 Code. If Illinois' federal medical assistance percentage
16 (FMAP) is reduced below 90% for persons eligible for
17 medical assistance under this paragraph 18, eligibility
18 under this paragraph 18 shall cease no later than the end
19 of the third month following the month in which the
20 reduction in FMAP takes effect.
21 19. Beginning January 1, 2014, as required under 42
22 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18
23 and younger than age 26 who are not otherwise eligible for
24 medical assistance under paragraphs (1) through (17) of
25 this Section who (i) were in foster care under the
26 responsibility of the State on the date of attaining age 18

or on the date of attaining age 21 when a court has continued wardship for good cause as provided in Section 2-31 of the Juvenile Court Act of 1987 and (ii) received medical assistance under the Illinois Title XIX State Plan or waiver of such plan while in foster care.

20. Beginning January 1, 2018, persons who are foreign-born victims of human trafficking, torture, or other serious crimes as defined in Section 2-19 of this Code and their derivative family members if such persons: (i) reside in Illinois; (ii) are not eligible under any of the preceding paragraphs; (iii) meet the income guidelines of subparagraph (a) of paragraph 2; and (iv) meet the nonfinancial eligibility requirements of Sections 16-2, 16-3, and 16-5 of this Code. The Department may extend medical assistance for persons who are foreign-born victims of human trafficking, torture, or other serious crimes whose medical assistance would be terminated pursuant to subsection (b) of Section 16-5 if the Department determines that the person, during the year of initial eligibility (1) experienced a health crisis, (2) has been unable, after reasonable attempts, to obtain necessary information from a third party, or (3) has other extenuating circumstances that prevented the person from completing his or her application for status. The Department may adopt any rules necessary to implement the provisions of this paragraph.

In implementing the provisions of Public Act 96-20, the Department is authorized to adopt only those rules necessary, including emergency rules. Nothing in Public Act 96-20 permits the Department to adopt rules or issue a decision that expands eligibility for the FamilyCare Program to a person whose income exceeds 185% of the Federal Poverty Level as determined from time to time by the U.S. Department of Health and Human Services, unless the Department is provided with express statutory authority.

The eligibility of any such person for medical assistance under this Article is not affected by the payment of any grant under the Senior Citizens and Persons with Disabilities Property Tax Relief Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act.

The Department shall by rule establish the amounts of assets to be disregarded in determining eligibility for medical assistance, which shall at a minimum equal the amounts to be disregarded under the Federal Supplemental Security Income Program. The amount of assets of a single person to be disregarded shall not be less than $2,000, and the amount of assets of a married couple to be disregarded shall not be less than $3,000.

To the extent permitted under federal law, any person found guilty of a second violation of Article VIIIA shall be ineligible for medical assistance under this Article, as

provided in Section 8A-8.

The eligibility of any person for medical assistance under this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person in cases of serious illness, as long as neither the person nor members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

Notwithstanding any other provision of this Code, if the United States Supreme Court holds Title II, Subtitle A, Section 2001(a) of Public Law 111-148 to be unconstitutional, or if a holding of Public Law 111-148 makes Medicaid eligibility allowed under Section 2001(a) inoperable, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal approval of a State Medicaid waiver on or after the effective date of this amendatory Act of the 97th General Assembly, and any individuals enrolled in the Medical Assistance Program pursuant to eligibility permitted as a result of such a State Medicaid waiver shall become immediately ineligible.

Notwithstanding any other provision of this Code, if an Act of Congress that becomes a Public Law eliminates Section 2001(a) of Public Law 111-148, the State or a unit of local government shall be prohibited from enrolling individuals in the Medical Assistance Program as the result of federal

1 approval of a State Medicaid waiver on or after the effective
2 date of this amendatory Act of the 97th General Assembly, and
3 any individuals enrolled in the Medical Assistance Program
4 pursuant to eligibility permitted as a result of such a State
5 Medicaid waiver shall become immediately ineligible.
6 Effective October 1, 2013, the determination of
7 eligibility of persons who qualify under paragraphs 5, 6, 8,
8 15, 17, and 18 of this Section shall comply with the
9 requirements of 42 U.S.C. 1396a(e)(14) and applicable federal
10 regulations.
11 The Department of Healthcare and Family Services, the
12 Department of Human Services, and the Illinois health insurance
13 marketplace shall work cooperatively to assist persons who
14 would otherwise lose health benefits as a result of changes
15 made under this amendatory Act of the 98th General Assembly to
16 transition to other health insurance coverage.
17 (Source: P.A. 98-104, eff. 7-22-13; 98-463, eff. 8-16-13;
18 99-143, eff. 7-27-15; 99-870, eff. 8-22-16.)

19 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
20 Sec. 5-5. Medical services. The Illinois Department, by
21 rule, shall determine the quantity and quality of and the rate
22 of reimbursement for the medical assistance for which payment
23 will be authorized, and the medical services to be provided,
24 which may include all or part of the following: (1) inpatient
25 hospital services; (2) outpatient hospital services; (3) other

1 laboratory and X-ray services; (4) skilled nursing home
2 services; (5) physicians' services whether furnished in the
3 office, the patient's home, a hospital, a skilled nursing home,
4 or elsewhere; (6) medical care, or any other type of remedial
5 care furnished by licensed practitioners; (7) home health care
6 services; (8) private duty nursing service; (9) clinic
7 services; (10) dental services, including prevention and
8 treatment of periodontal disease and dental caries disease for
9 pregnant women, provided by an individual licensed to practice
10 dentistry or dental surgery; for purposes of this item (10),
11 "dental services" means diagnostic, preventive, or corrective
12 procedures provided by or under the supervision of a dentist in
13 the practice of his or her profession; (11) physical therapy
14 and related services; (12) prescribed drugs, dentures, and
15 prosthetic devices; and eyeglasses prescribed by a physician
16 skilled in the diseases of the eye, or by an optometrist,
17 whichever the person may select; (13) other diagnostic,
18 screening, preventive, and rehabilitative services, including
19 to ensure that the individual's need for intervention or
20 treatment of mental disorders or substance use disorders or
21 co-occurring mental health and substance use disorders is
22 determined using a uniform screening, assessment, and
23 evaluation process inclusive of criteria, for children and
24 adults; for purposes of this item (13), a uniform screening,
25 assessment, and evaluation process refers to a process that
26 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. 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, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical 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 physician's handwritten signature appear on the laboratory test order form. The Illinois Department may, however, impose other appropriate requirements regarding laboratory test order documentation.

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

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

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

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

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

On and after July 1, 2018, targeted dental services, as set forth in Exhibit D of the Consent Decree entered by the United States District Court for the Northern District of Illinois, Eastern Division, in the matter of Memisovski v. Maram, Case

No. 92 C 1982, that are provided to adults under the medical assistance program shall be established at no less than the rates set forth in the "New Rate" column in Exhibit D of the Consent Decree for targeted dental services that are provided to persons under the age of 18 under the medical assistance program.

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 and MRI 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,

1 instruction on self-examination and information regarding the
2 frequency of self-examination and its value as a preventative
3 tool. For purposes of this Section, "low-dose mammography"
4 means the x-ray examination of the breast using equipment
5 dedicated specifically for mammography, including the x-ray
6 tube, filter, compression device, and image receptor, with an
7 average radiation exposure delivery of less than one rad per
8 breast for 2 views of an average size breast. The term also
9 includes digital mammography and includes breast
10 tomosynthesis. As used in this Section, the term "breast
11 tomosynthesis" means a radiologic procedure that involves the
12 acquisition of projection images over the stationary breast to
13 produce cross-sectional digital three-dimensional images of
14 the breast. If, at any time, the Secretary of the United States
15 Department of Health and Human Services, or its successor
16 agency, promulgates rules or regulations to be published in the
17 Federal Register or publishes a comment in the Federal Register
18 or issues an opinion, guidance, or other action that would
19 require the State, pursuant to any provision of the Patient
20 Protection and Affordable Care Act (Public Law 111-148),
21 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
22 successor provision, to defray the cost of any coverage for
23 breast tomosynthesis outlined in this paragraph, then the
24 requirement that an insurer cover breast tomosynthesis is
25 inoperative other than any such coverage authorized under
26 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and

1 the State shall not assume any obligation for the cost of
2 coverage for breast tomosynthesis set forth in this paragraph.
3 On and after January 1, 2016, the Department shall ensure
4 that all networks of care for adult clients of the Department
5 include access to at least one breast imaging Center of Imaging
6 Excellence as certified by the American College of Radiology.
7 On and after January 1, 2012, providers participating in a
8 quality improvement program approved by the Department shall be
9 reimbursed for screening and diagnostic mammography at the same
10 rate as the Medicare program's rates, including the increased
11 reimbursement for digital mammography.
12 The Department shall convene an expert panel including
13 representatives of hospitals, free-standing mammography
14 facilities, and doctors, including radiologists, to establish
15 quality standards for mammography.
16 On and after January 1, 2017, providers participating in a
17 breast cancer treatment quality improvement program approved
18 by the Department shall be reimbursed for breast cancer
19 treatment at a rate that is no lower than 95% of the Medicare
20 program's rates for the data elements included in the breast
21 cancer treatment quality program.
22 The Department shall convene an expert panel, including
23 representatives of hospitals, free-standing breast cancer
24 treatment centers, breast cancer quality organizations, and
25 doctors, including breast surgeons, reconstructive breast
26 surgeons, oncologists, and primary care providers to establish

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.

On or after July 1, 2019, women who are otherwise eligible for medical assistance under this Article shall receive coverage for doula services by a certified doula during their pregnancy and during the 12-month period beginning on the last day of their pregnancy. As used in this paragraph, "certified doula" means an individual who has received a certification to perform doula services from the International Childbirth

1 Education Association, the Doulas of North America, the
2 Association of Labor Assistants and Childbirth Educators,
3 BirthWorks, the Childbirth and Postpartum Professional
4 Association, Childbirth International, the International
5 Center for Traditional Childbearing, or Commonsense Childbirth
6 Inc. As used in this paragraph, "doula services" means
7 continuous personal, non-medical emotional and physical
8 support throughout labor and birth, and intermittently during
9 the prenatal and postpartum periods.

10 On or after July 1, 2019, women who are otherwise eligible
11 for medical assistance under this Article shall receive
12 coverage for perinatal depression screenings for the 12-month
13 period beginning on the last day of their pregnancy. Medical
14 assistance coverage under this paragraph shall be conditioned
15 on the use of a screening instrument approved by the
16 Department.

17 Any medical or health care provider shall immediately
18 recommend, to any pregnant woman who is being provided prenatal
19 services and is suspected of having a substance use disorder as
20 defined in the Substance Use Disorder Act, referral to a local
21 substance use disorder treatment program licensed by the
22 Department of Human Services or to a licensed hospital which
23 provides substance abuse treatment services. The Department of
24 Healthcare and Family Services shall assure coverage for the
25 cost of treatment of the drug abuse or addiction for pregnant
26 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 any 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

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

approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after September 16, 1984 (the effective date of Public Act 83-1439), 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.

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

1 home claims.

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

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

21 The Illinois Department may require that all dispensers of
22 medical services desiring to participate in the medical
23 assistance program established under this Article disclose,
24 under such terms and conditions as the Illinois Department may
25 by rule establish, all inquiries from clients and attorneys
26 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 adjudication by the primary payer.

In the case of long term care facilities, within 45 calendar days of receipt by the facility of required prescreening information, new admissions with associated admission documents shall be submitted through the Medical Electronic Data Interchange (MEDI) or the Recipient Eligibility Verification (REV) System 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 exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight.

1 The Illinois Department shall develop, in cooperation with
2 other State departments and agencies, and in compliance with
3 applicable federal laws and regulations, appropriate and
4 effective methods to share such data. At a minimum, and to the
5 extent necessary to provide data sharing, the Illinois
6 Department shall enter into agreements with State agencies and
7 departments, and is authorized to enter into agreements with
8 federal agencies and departments, including but not limited to:
9 the Secretary of State; the Department of Revenue; the
10 Department of Public Health; the Department of Human Services;
11 and the Department of Financial and Professional Regulation.
12 Beginning in fiscal year 2013, the Illinois Department
13 shall set forth a request for information to identify the
14 benefits of a pre-payment, post-adjudication, and post-edit
15 claims system with the goals of streamlining claims processing
16 and provider reimbursement, reducing the number of pending or
17 rejected claims, and helping to ensure a more transparent
18 adjudication process through the utilization of: (i) provider
19 data verification and provider screening technology; and (ii)
20 clinical code editing; and (iii) pre-pay, pre- or
21 post-adjudicated predictive modeling with an integrated case
22 management system with link analysis. Such a request for
23 information shall not be considered as a request for proposal
24 or as an obligation on the part of the Illinois Department to
25 take any action or acquire any products or services.
26 The Illinois Department shall establish policies,

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

The Department shall require, by rule, all providers of durable medical equipment to be accredited by an accreditation organization approved by the federal Centers for Medicare and Medicaid Services and recognized by the Department in order to bill the Department for providing durable medical equipment to recipients. No later than 15 months after the effective date of

1 the rule adopted pursuant to this paragraph, all providers must
2 meet the accreditation requirement.
3 In order to promote environmental responsibility, meet the
4 needs of recipients and enrollees, and achieve significant cost
5 savings, the Department, or a managed care organization under
6 contract with the Department, may provide recipients or managed
7 care enrollees who have a prescription or Certificate of
8 Medical Necessity access to refurbished durable medical
9 equipment under this Section (excluding prosthetic and
10 orthotic devices as defined in the Orthotics, Prosthetics, and
11 Pedorthics Practice Act and complex rehabilitation technology
12 products and associated services) through the State's
13 assistive technology program's reutilization program, using
14 staff with the Assistive Technology Professional (ATP)
15 Certification if the refurbished durable medical equipment:
16 (i) is available; (ii) is less expensive, including shipping
17 costs, than new durable medical equipment of the same type;
18 (iii) is able to withstand at least 3 years of use; (iv) is
19 cleaned, disinfected, sterilized, and safe in accordance with
20 federal Food and Drug Administration regulations and guidance
21 governing the reprocessing of medical devices in health care
22 settings; and (v) equally meets the needs of the recipient or
23 enrollee. The reutilization program shall confirm that the
24 recipient or enrollee is not already in receipt of same or
25 similar equipment from another service provider, and that the
26 refurbished durable medical equipment equally meets the needs

of the recipient or enrollee. Nothing in this paragraph shall be construed to limit recipient or enrollee choice to obtain new durable medical equipment or place any additional prior authorization conditions on enrollees of managed care organizations.

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

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

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

17 The Illinois Department shall report annually to the
18 General Assembly, no later than the second Friday in April of
19 1979 and each year thereafter, in regard to:

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

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

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

26 (d) efforts at utilization review and control by the

1 Illinois Department.
2 The period covered by each report shall be the 3 years
3 ending on the June 30 prior to the report. The report shall
4 include suggested legislation for consideration by the General
5 Assembly. The requirement for reporting to the General Assembly
6 shall be satisfied by filing copies of the report as required
7 by Section 3.1 of the General Assembly Organization Act, and
8 filing such additional copies with the State Government Report
9 Distribution Center for the General Assembly as is required
10 under paragraph (t) of Section 7 of the State Library Act.
11 Rulemaking authority to implement Public Act 95-1045, if
12 any, is conditioned on the rules being adopted in accordance
13 with all provisions of the Illinois Administrative Procedure
14 Act and all rules and procedures of the Joint Committee on
15 Administrative Rules; any purported rule not so adopted, for
16 whatever reason, is unauthorized.
17 On and after July 1, 2012, the Department shall reduce any
18 rate of reimbursement for services or other payments or alter
19 any methodologies authorized by this Code to reduce any rate of
20 reimbursement for services or other payments in accordance with
21 Section 5-5e.
22 Because kidney transplantation can be an appropriate,
23 cost-effective alternative to renal dialysis when medically
24 necessary and notwithstanding the provisions of Section 1-11 of
25 this Code, beginning October 1, 2014, the Department shall
26 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 dialysis services covered by the Department. Providers under this Section shall be prior approved and certified by the Department to perform kidney transplantation and the services under this Section shall be limited to services associated with kidney transplantation.

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

On or after July 1, 2015, opioid antagonists prescribed for 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.

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

working under the general supervision of a dentist and employed by a federally qualified health center.

Notwithstanding any other provision of this Code, the Illinois Department shall authorize licensed dietitian nutritionists and certified diabetes educators to counsel senior diabetes patients in the senior diabetes patients' homes to remove the hurdle of transportation for senior diabetes patients to receive treatment.

The Department shall seek approval of a State Plan amendment to expand coverage for family planning services to women whose income is at or below 200% of the federal poverty level.

(Source: P.A. 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; 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff. 12-10-18.)

(305 ILCS 5/5-5.24)

Sec. 5-5.24. Prenatal and perinatal care. The Department of Healthcare and Family Services may provide reimbursement under

1 this Article for all prenatal and perinatal health care
2 services that are provided for the purpose of preventing
3 low-birthweight infants, reducing the need for neonatal
4 intensive care hospital services, and promoting perinatal and
5 maternal health. These services may include comprehensive risk
6 assessments for pregnant women, women with infants, and
7 infants, lactation counseling, nutrition counseling,
8 childbirth support, psychosocial counseling, treatment and
9 prevention of periodontal disease, language translation, nurse
10 home visitation, and other support services that have been
11 proven to improve birth and maternal health outcomes. The
12 Department shall maximize the use of preventive prenatal and
13 perinatal health care services consistent with federal
14 statutes, rules, and regulations. The Department of Public Aid
15 (now Department of Healthcare and Family Services) shall
16 develop a plan for prenatal and perinatal preventive health
17 care and shall present the plan to the General Assembly by
18 January 1, 2004. On or before January 1, 2006 and every 2 years
19 thereafter, the Department shall report to the General Assembly
20 concerning the effectiveness of prenatal and perinatal health
21 care services reimbursed under this Section in preventing
22 low-birthweight infants and reducing the need for neonatal
23 intensive care hospital services. Each such report shall
24 include an evaluation of how the ratio of expenditures for
25 treating low-birthweight infants compared with the investment
26 in promoting healthy births and infants in local community

areas throughout Illinois relates to healthy infant development in those areas.

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.

(Source: P.A. 97-689, eff. 6-14-12.)

Section 55. The Developmental Disability Prevention Act is amended by adding Section 11.2 as follows:

(410 ILCS 250/11.2 new)

Sec. 11.2. Birthing facilities; maternal care designations.

(a) In this Section, "birthing facility" means: (1) a hospital, as defined in the Hospital Licensing Act, with more than one licensed obstetric bed or a neonatal intensive care unit; (2) a hospital operated by a State university; or (3) a birth center, as defined in the Alternative Health Care Delivery Act.

(b) Every birthing facility shall, at a minimum, have an obstetric hemorrhage protocol and conduct a drill or simulation of the protocol. Every contracted provider who may encounter a pregnant woman shall participate in the drill or simulation on a regular basis. The Department shall adopt rules to implement

this subsection.

(c) After holding multiple public hearings with representatives from diverse geographical regions and professional backgrounds and seeking broad public and stakeholder input, the Department shall establish criteria for levels of maternal care designations for birthing facilities. All hearings shall be open to the public and held at specific times and places that are convenient and available to the public. No hearing shall be held on a legal holiday. Public notice of hearings shall state the dates, times, and places of the hearings. Notice of hearings shall be posted on the Department's website and in the Department's main office, and minutes from the hearings shall be recorded. The levels of maternal care designations developed under this Section shall be based upon:

(1) the most current published version of the "Levels of Maternal Care" developed by the American Congress of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine; and

(2) necessary variance when considering the geographic and varied needs of citizens of this State.

(d) Nothing in this Section shall be construed in any way to modify or expand the licensure of any health care professional.

(e) Nothing in this Section shall be construed in any way to require a patient to be transferred to a different facility.

1 (f) The Department shall adopt rules to implement the
2 provisions of this Section no later than June 1, 2021. These
3 rules shall be limited to those necessary for the establishment
4 of levels of maternal care designations for birthing facilities
5 under subsection (c) of this Section.

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

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