

1 AN ACT concerning health insurance co-pays.

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

4 Section 5. The Illinois Insurance Code is amended by  
5 changing Section 356z.23 as follows:

6 (215 ILCS 5/356z.23)

7 Sec. 356z.23. Coverage for opioid antagonists.

8 (a) An individual or group policy of accident and health  
9 insurance amended, delivered, issued, or renewed in this State  
10 after the effective date of this amendatory Act of the 99th  
11 General Assembly that provides coverage for prescription drugs  
12 must provide coverage for at least one opioid antagonist,  
13 including the medication product, administration devices, and  
14 any pharmacy administration fees related to the dispensing of  
15 the opioid antagonist. This coverage must include refills for  
16 expired or utilized opioid antagonists.

17 (a-5) Notwithstanding subsection (a), no individual or  
18 group policy of accident and health insurance amended,  
19 delivered, issued, or renewed after January 1, 2024 that  
20 provides coverage for naloxone hydrochloride shall impose a  
21 copayment on the coverage provided, except that this  
22 subsection does not apply to coverage of naloxone  
23 hydrochloride to the extent such coverage would disqualify a

1 high-deductible health plan from eligibility for a health  
2 savings account under Section 223 of the Internal Revenue  
3 Code.

4 (b) As used in this Section, "opioid antagonist" means a  
5 drug that binds to opioid receptors and blocks or inhibits the  
6 effect of opioids acting on those receptors, including, but  
7 not limited to, naloxone hydrochloride or any other similarly  
8 acting drug approved by the U.S. Food and Drug Administration.

9 (Source: P.A. 99-480, eff. 9-9-15.)

10 Section 10. The Illinois Public Aid Code is amended by  
11 changing Section 5-5 as follows:

12 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

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

1 sexual assault, including examinations and laboratory tests to  
2 discover evidence which may be used in criminal proceedings  
3 arising from the sexual assault; (16) the diagnosis and  
4 treatment of sickle cell anemia; (16.5) services performed by  
5 a chiropractic physician licensed under the Medical Practice  
6 Act of 1987 and acting within the scope of his or her license,  
7 including, but not limited to, chiropractic manipulative  
8 treatment; and (17) any other medical care, and any other type  
9 of remedial care recognized under the laws of this State. The  
10 term "any other type of remedial care" shall include nursing  
11 care and nursing home service for persons who rely on  
12 treatment by spiritual means alone through prayer for healing.

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

20 Notwithstanding any other provision of this Code,  
21 reproductive health care that is otherwise legal in Illinois  
22 shall be covered under the medical assistance program for  
23 persons who are otherwise eligible for medical assistance  
24 under this Article.

25 Notwithstanding any other provision of this Section, all  
26 tobacco cessation medications approved by the United States

1 Food and Drug Administration and all individual and group  
2 tobacco cessation counseling services and telephone-based  
3 counseling services and tobacco cessation medications provided  
4 through the Illinois Tobacco Quitline shall be covered under  
5 the medical assistance program for persons who are otherwise  
6 eligible for assistance under this Article. The Department  
7 shall comply with all federal requirements necessary to obtain  
8 federal financial participation, as specified in 42 CFR  
9 433.15(b)(7), for telephone-based counseling services provided  
10 through the Illinois Tobacco Quitline, including, but not  
11 limited to: (i) entering into a memorandum of understanding or  
12 interagency agreement with the Department of Public Health, as  
13 administrator of the Illinois Tobacco Quitline; and (ii)  
14 developing a cost allocation plan for Medicaid-allowable  
15 Illinois Tobacco Quitline services in accordance with 45 CFR  
16 95.507. The Department shall submit the memorandum of  
17 understanding or interagency agreement, the cost allocation  
18 plan, and all other necessary documentation to the Centers for  
19 Medicare and Medicaid Services for review and approval.  
20 Coverage under this paragraph shall be contingent upon federal  
21 approval.

22 Notwithstanding any other provision of this Code, the  
23 Illinois Department may not require, as a condition of payment  
24 for any laboratory test authorized under this Article, that a  
25 physician's handwritten signature appear on the laboratory  
26 test order form. The Illinois Department may, however, impose

1 other appropriate requirements regarding laboratory test order  
2 documentation.

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

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

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

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

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

17           On and after July 1, 2018, targeted dental services, as  
18 set forth in Exhibit D of the Consent Decree entered by the  
19 United States District Court for the Northern District of  
20 Illinois, Eastern Division, in the matter of Memisovski v.  
21 Maram, Case No. 92 C 1982, that are provided to adults under  
22 the medical assistance program shall be established at no less  
23 than the rates set forth in the "New Rate" column in Exhibit D  
24 of the Consent Decree for targeted dental services that are  
25 provided to persons under the age of 18 under the medical  
26 assistance program.

1           Notwithstanding any other provision of this Code and  
2 subject to federal approval, the Department may adopt rules to  
3 allow a dentist who is volunteering his or her service at no  
4 cost to render dental services through an enrolled  
5 not-for-profit health clinic without the dentist personally  
6 enrolling as a participating provider in the medical  
7 assistance program. A not-for-profit health clinic shall  
8 include a public health clinic or Federally Qualified Health  
9 Center or other enrolled provider, as determined by the  
10 Department, through which dental services covered under this  
11 Section are performed. The Department shall establish a  
12 process for payment of claims for reimbursement for covered  
13 dental services rendered under this provision.

14           On and after January 1, 2022, the Department of Healthcare  
15 and Family Services shall administer and regulate a  
16 school-based dental program that allows for the out-of-office  
17 delivery of preventative dental services in a school setting  
18 to children under 19 years of age. The Department shall  
19 establish, by rule, guidelines for participation by providers  
20 and set requirements for follow-up referral care based on the  
21 requirements established in the Dental Office Reference Manual  
22 published by the Department that establishes the requirements  
23 for dentists participating in the All Kids Dental School  
24 Program. Every effort shall be made by the Department when  
25 developing the program requirements to consider the different  
26 geographic differences of both urban and rural areas of the



1 State for initial treatment and necessary follow-up care. No  
2 provider shall be charged a fee by any unit of local government  
3 to participate in the school-based dental program administered  
4 by the Department. Nothing in this paragraph shall be  
5 construed to limit or preempt a home rule unit's or school  
6 district's authority to establish, change, or administer a  
7 school-based dental program in addition to, or independent of,  
8 the school-based dental program administered by the  
9 Department.

10 The Illinois Department, by rule, may distinguish and  
11 classify the medical services to be provided only in  
12 accordance with the classes of persons designated in Section  
13 5-2.

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

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

26 (A) A baseline mammogram for individuals 35 to 39

1 years of age.

2 (B) An annual mammogram for individuals 40 years of  
3 age or older.

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

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

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

18 (F) A diagnostic mammogram when medically necessary,  
19 as determined by a physician licensed to practice medicine  
20 in all its branches, advanced practice registered nurse,  
21 or physician assistant.

22 The Department shall not impose a deductible, coinsurance,  
23 copayment, or any other cost-sharing requirement on the  
24 coverage provided under this paragraph; except that this  
25 sentence does not apply to coverage of diagnostic mammograms  
26 to the extent such coverage would disqualify a high-deductible

1 health plan from eligibility for a health savings account  
2 pursuant to Section 223 of the Internal Revenue Code (26  
3 U.S.C. 223).

4 All screenings shall include a physical breast exam,  
5 instruction on self-examination and information regarding the  
6 frequency of self-examination and its value as a preventative  
7 tool.

8 For purposes of this Section:

9 "Diagnostic mammogram" means a mammogram obtained using  
10 diagnostic mammography.

11 "Diagnostic mammography" means a method of screening that  
12 is designed to evaluate an abnormality in a breast, including  
13 an abnormality seen or suspected on a screening mammogram or a  
14 subjective or objective abnormality otherwise detected in the  
15 breast.

16 "Low-dose mammography" means the x-ray examination of the  
17 breast using equipment dedicated specifically for mammography,  
18 including the x-ray tube, filter, compression device, and  
19 image receptor, with an average radiation exposure delivery of  
20 less than one rad per breast for 2 views of an average size  
21 breast. The term also includes digital mammography and  
22 includes breast tomosynthesis.

23 "Breast tomosynthesis" means a radiologic procedure that  
24 involves the acquisition of projection images over the  
25 stationary breast to produce cross-sectional digital  
26 three-dimensional images of the breast.

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

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

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

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

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

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

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

24           The Department shall establish a methodology to remind  
25 individuals who are age-appropriate for screening mammography,  
26 but who have not received a mammogram within the previous 18

1 months, of the importance and benefit of screening  
2 mammography. The Department shall work with experts in breast  
3 cancer outreach and patient navigation to optimize these  
4 reminders and shall establish a methodology for evaluating  
5 their effectiveness and modifying the methodology based on the  
6 evaluation.

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

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

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

9           On or after July 1, 2022, individuals who are otherwise  
10 eligible for medical assistance under this Article shall  
11 receive coverage for perinatal depression screenings for the  
12 12-month period beginning on the last day of their pregnancy.  
13 Medical assistance coverage under this paragraph shall be  
14 conditioned on the use of a screening instrument approved by  
15 the Department.

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

1 of Human Services.

2 All medical providers providing medical assistance to  
3 pregnant individuals under this Code shall receive information  
4 from the Department on the availability of services under any  
5 program providing case management services for addicted  
6 individuals, including information on appropriate referrals  
7 for other social services that may be needed by addicted  
8 individuals in addition to treatment for addiction.

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

17 Neither the Department of Healthcare and Family Services  
18 nor the Department of Human Services shall sanction the  
19 recipient solely on the basis of the recipient's substance  
20 abuse.

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



1 information dissemination and educational activities for  
2 medical and health care providers, and consistency in  
3 procedures to the Illinois Department.

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

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

24 (1) Physicians participating in a Partnership and  
25 providing certain services, which shall be determined by  
26 the Illinois Department, to persons in areas covered by

1 the Partnership may receive an additional surcharge for  
2 such services.

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

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

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

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

1 service providers.

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

5 The Illinois Department shall require health care  
6 providers to maintain records that document the medical care  
7 and services provided to recipients of Medical Assistance  
8 under this Article. Such records must be retained for a period  
9 of not less than 6 years from the date of service or as  
10 provided by applicable State law, whichever period is longer,  
11 except that if an audit is initiated within the required  
12 retention period then the records must be retained until the  
13 audit is completed and every exception is resolved. The  
14 Illinois Department shall require health care providers to  
15 make available, when authorized by the patient, in writing,  
16 the medical records in a timely fashion to other health care  
17 providers who are treating or serving persons eligible for  
18 Medical Assistance under this Article. All dispensers of  
19 medical services shall be required to maintain and retain  
20 business and professional records sufficient to fully and  
21 accurately document the nature, scope, details and receipt of  
22 the health care provided to persons eligible for medical  
23 assistance under this Code, in accordance with regulations  
24 promulgated by the Illinois Department. The rules and  
25 regulations shall require that proof of the receipt of  
26 prescription drugs, dentures, prosthetic devices and

1 eyeglasses by eligible persons under this Section accompany  
2 each claim for reimbursement submitted by the dispenser of  
3 such medical services. No such claims for reimbursement shall  
4 be approved for payment by the Illinois Department without  
5 such proof of receipt, unless the Illinois Department shall  
6 have put into effect and shall be operating a system of  
7 post-payment audit and review which shall, on a sampling  
8 basis, be deemed adequate by the Illinois Department to assure  
9 that such drugs, dentures, prosthetic devices and eyeglasses  
10 for which payment is being made are actually being received by  
11 eligible recipients. Within 90 days after September 16, 1984  
12 (the effective date of Public Act 83-1439), the Illinois  
13 Department shall establish a current list of acquisition costs  
14 for all prosthetic devices and any other items recognized as  
15 medical equipment and supplies reimbursable under this Article  
16 and shall update such list on a quarterly basis, except that  
17 the acquisition costs of all prescription drugs shall be  
18 updated no less frequently than every 30 days as required by  
19 Section 5-5.12.

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

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

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

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

25 The Illinois Department may require that all dispensers of  
26 medical services desiring to participate in the medical

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

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

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

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

1 certification, and authorization verifications; unscheduled or  
2 unannounced site visits; database checks; prepayment audit  
3 reviews; audits; payment caps; payment suspensions; and other  
4 screening as required by federal or State law.

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

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

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

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

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

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

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

19          In the case of long term care facilities, within 120  
20          calendar days of receipt by the facility of required  
21          prescreening information, new admissions with associated  
22          admission documents shall be submitted through the Medical  
23          Electronic Data Interchange (MEDI) or the Recipient  
24          Eligibility Verification (REV) System or shall be submitted  
25          directly to the Department of Human Services using required  
26          admission forms. Effective September 1, 2014, admission



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

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

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

26 The Illinois Department shall enter into agreements with

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

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

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

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

26 The Department shall require, by rule, all providers of

1 durable medical equipment to be accredited by an accreditation  
2 organization approved by the federal Centers for Medicare and  
3 Medicaid Services and recognized by the Department in order to  
4 bill the Department for providing durable medical equipment to  
5 recipients. No later than 15 months after the effective date  
6 of the rule adopted pursuant to this paragraph, all providers  
7 must meet the accreditation requirement.

8 In order to promote environmental responsibility, meet the  
9 needs of recipients and enrollees, and achieve significant  
10 cost savings, the Department, or a managed care organization  
11 under contract with the Department, may provide recipients or  
12 managed care enrollees who have a prescription or Certificate  
13 of Medical Necessity access to refurbished durable medical  
14 equipment under this Section (excluding prosthetic and  
15 orthotic devices as defined in the Orthotics, Prosthetics, and  
16 Pedorthics Practice Act and complex rehabilitation technology  
17 products and associated services) through the State's  
18 assistive technology program's reutilization program, using  
19 staff with the Assistive Technology Professional (ATP)  
20 Certification if the refurbished durable medical equipment:  
21 (i) is available; (ii) is less expensive, including shipping  
22 costs, than new durable medical equipment of the same type;  
23 (iii) is able to withstand at least 3 years of use; (iv) is  
24 cleaned, disinfected, sterilized, and safe in accordance with  
25 federal Food and Drug Administration regulations and guidance  
26 governing the reprocessing of medical devices in health care

1 settings; and (v) equally meets the needs of the recipient or  
2 enrollee. The reutilization program shall confirm that the  
3 recipient or enrollee is not already in receipt of the same or  
4 similar equipment from another service provider, and that the  
5 refurbished durable medical equipment equally meets the needs  
6 of the recipient or enrollee. Nothing in this paragraph shall  
7 be construed to limit recipient or enrollee choice to obtain  
8 new durable medical equipment or place any additional prior  
9 authorization conditions on enrollees of managed care  
10 organizations.

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

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

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

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

26 (a) actual statistics and trends in utilization of

1 medical services by public aid recipients;

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

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

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

8 The period covered by each report shall be the 3 years  
9 ending on the June 30 prior to the report. The report shall  
10 include suggested legislation for consideration by the General  
11 Assembly. The requirement for reporting to the General  
12 Assembly shall be satisfied by filing copies of the report as  
13 required by Section 3.1 of the General Assembly Organization  
14 Act, and filing such additional copies with the State  
15 Government Report Distribution Center for the General Assembly  
16 as is required under paragraph (t) of Section 7 of the State  
17 Library Act.

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

24 On and after July 1, 2012, the Department shall reduce any  
25 rate of reimbursement for services or other payments or alter  
26 any methodologies authorized by this Code to reduce any rate

1 of reimbursement for services or other payments in accordance  
2 with Section 5-5e.

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

19 Notwithstanding any other provision of this Code to the  
20 contrary, on or after July 1, 2015, all FDA approved forms of  
21 medication assisted treatment prescribed for the treatment of  
22 alcohol dependence or treatment of opioid dependence shall be  
23 covered under both fee for service and managed care medical  
24 assistance programs for persons who are otherwise eligible for  
25 medical assistance under this Article and shall not be subject  
26 to any (1) utilization control, other than those established



1 under the American Society of Addiction Medicine patient  
2 placement criteria, (2) prior authorization mandate, or (3)  
3 lifetime restriction limit mandate.

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

19 Upon federal approval, the Department shall provide  
20 coverage and reimbursement for all drugs that are approved for  
21 marketing by the federal Food and Drug Administration and that  
22 are recommended by the federal Public Health Service or the  
23 United States Centers for Disease Control and Prevention for  
24 pre-exposure prophylaxis and related pre-exposure prophylaxis  
25 services, including, but not limited to, HIV and sexually  
26 transmitted infection screening, treatment for sexually

1 transmitted infections, medical monitoring, assorted labs, and  
2 counseling to reduce the likelihood of HIV infection among  
3 individuals who are not infected with HIV but who are at high  
4 risk of HIV infection.

5 A federally qualified health center, as defined in Section  
6 1905(1)(2)(B) of the federal Social Security Act, shall be  
7 reimbursed by the Department in accordance with the federally  
8 qualified health center's encounter rate for services provided  
9 to medical assistance recipients that are performed by a  
10 dental hygienist, as defined under the Illinois Dental  
11 Practice Act, working under the general supervision of a  
12 dentist and employed by a federally qualified health center.

13 Within 90 days after October 8, 2021 (the effective date  
14 of Public Act 102-665) ~~this amendatory Act of the 102nd~~  
15 ~~General Assembly~~, the Department shall seek federal approval  
16 of a State Plan amendment to expand coverage for family  
17 planning services that includes presumptive eligibility to  
18 individuals whose income is at or below 208% of the federal  
19 poverty level. Coverage under this Section shall be effective  
20 beginning no later than December 1, 2022.

21 Subject to approval by the federal Centers for Medicare  
22 and Medicaid Services of a Title XIX State Plan amendment  
23 electing the Program of All-Inclusive Care for the Elderly  
24 (PACE) as a State Medicaid option, as provided for by Subtitle  
25 I (commencing with Section 4801) of Title IV of the Balanced  
26 Budget Act of 1997 (Public Law 105-33) and Part 460

1 (commencing with Section 460.2) of Subchapter E of Title 42 of  
2 the Code of Federal Regulations, PACE program services shall  
3 become a covered benefit of the medical assistance program,  
4 subject to criteria established in accordance with all  
5 applicable laws.

6 Notwithstanding any other provision of this Code,  
7 community-based pediatric palliative care from a trained  
8 interdisciplinary team shall be covered under the medical  
9 assistance program as provided in Section 15 of the Pediatric  
10 Palliative Care Act.

11 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;  
12 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article  
13 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section  
14 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;  
15 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.  
16 1-1-22; 102-665, eff. 10-8-21; revised 11-18-21.)