

1 AN ACT concerning regulation.

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 370c as follows:

6 (215 ILCS 5/370c) (from Ch. 73, par. 982c)

7 Sec. 370c. Mental and emotional disorders.

8 (a) (1) On and after January 1, 2022 (the effective date of
9 Public Act 102-579), every insurer that amends, delivers,
10 issues, or renews group accident and health policies providing
11 coverage for hospital or medical treatment or services for
12 illness on an expense-incurred basis shall provide coverage
13 for the medically necessary treatment of mental, emotional,
14 nervous, or substance use disorders or conditions consistent
15 with the parity requirements of Section 370c.1 of this Code.

16 (2) Each insured that is covered for mental, emotional,
17 nervous, or substance use disorders or conditions shall be
18 free to select the physician licensed to practice medicine in
19 all its branches, licensed clinical psychologist, licensed
20 clinical social worker, licensed clinical professional
21 counselor, licensed marriage and family therapist, licensed
22 speech-language pathologist, or other licensed or certified
23 professional at a program licensed pursuant to the Substance

1 Use Disorder Act of his or her choice to treat such disorders,
2 and the insurer shall pay the covered charges of such
3 physician licensed to practice medicine in all its branches,
4 licensed clinical psychologist, licensed clinical social
5 worker, licensed clinical professional counselor, licensed
6 marriage and family therapist, licensed speech-language
7 pathologist, or other licensed or certified professional at a
8 program licensed pursuant to the Substance Use Disorder Act up
9 to the limits of coverage, provided (i) the disorder or
10 condition treated is covered by the policy, and (ii) the
11 physician, licensed psychologist, licensed clinical social
12 worker, licensed clinical professional counselor, licensed
13 marriage and family therapist, licensed speech-language
14 pathologist, or other licensed or certified professional at a
15 program licensed pursuant to the Substance Use Disorder Act is
16 authorized to provide said services under the statutes of this
17 State and in accordance with accepted principles of his or her
18 profession.

19 (3) Insofar as this Section applies solely to licensed
20 clinical social workers, licensed clinical professional
21 counselors, licensed marriage and family therapists, licensed
22 speech-language pathologists, and other licensed or certified
23 professionals at programs licensed pursuant to the Substance
24 Use Disorder Act, those persons who may provide services to
25 individuals shall do so after the licensed clinical social
26 worker, licensed clinical professional counselor, licensed

1 marriage and family therapist, licensed speech-language
2 pathologist, or other licensed or certified professional at a
3 program licensed pursuant to the Substance Use Disorder Act
4 has informed the patient of the desirability of the patient
5 conferring with the patient's primary care physician.

6 (4) "Mental, emotional, nervous, or substance use disorder
7 or condition" means a condition or disorder that involves a
8 mental health condition or substance use disorder that falls
9 under any of the diagnostic categories listed in the mental
10 and behavioral disorders chapter of the current edition of the
11 World Health Organization's International Classification of
12 Disease or that is listed in the most recent version of the
13 American Psychiatric Association's Diagnostic and Statistical
14 Manual of Mental Disorders. "Mental, emotional, nervous, or
15 substance use disorder or condition" includes any mental
16 health condition that occurs during pregnancy or during the
17 postpartum period and includes, but is not limited to,
18 postpartum depression.

19 (5) Medically necessary treatment and medical necessity
20 determinations shall be interpreted and made in a manner that
21 is consistent with and pursuant to subsections (h) through
22 (t).

23 (b) (1) (Blank).

24 (2) (Blank).

25 (2.5) (Blank).

26 (3) Unless otherwise prohibited by federal law and

1 consistent with the parity requirements of Section 370c.1 of
2 this Code, the reimbursing insurer that amends, delivers,
3 issues, or renews a group or individual policy of accident and
4 health insurance, a qualified health plan offered through the
5 health insurance marketplace, or a provider of treatment of
6 mental, emotional, nervous, or substance use disorders or
7 conditions shall furnish medical records or other necessary
8 data that substantiate that initial or continued treatment is
9 at all times medically necessary. An insurer shall provide a
10 mechanism for the timely review by a provider holding the same
11 license and practicing in the same specialty as the patient's
12 provider, who is unaffiliated with the insurer, jointly
13 selected by the patient (or the patient's next of kin or legal
14 representative if the patient is unable to act for himself or
15 herself), the patient's provider, and the insurer in the event
16 of a dispute between the insurer and patient's provider
17 regarding the medical necessity of a treatment proposed by a
18 patient's provider. If the reviewing provider determines the
19 treatment to be medically necessary, the insurer shall provide
20 reimbursement for the treatment. Future contractual or
21 employment actions by the insurer regarding the patient's
22 provider may not be based on the provider's participation in
23 this procedure. Nothing prevents the insured from agreeing in
24 writing to continue treatment at his or her expense. When
25 making a determination of the medical necessity for a
26 treatment modality for mental, emotional, nervous, or

1 substance use disorders or conditions, an insurer must make
2 the determination in a manner that is consistent with the
3 manner used to make that determination with respect to other
4 diseases or illnesses covered under the policy, including an
5 appeals process. Medical necessity determinations for
6 substance use disorders shall be made in accordance with
7 appropriate patient placement criteria established by the
8 American Society of Addiction Medicine. No additional criteria
9 may be used to make medical necessity determinations for
10 substance use disorders.

11 (4) A group health benefit plan amended, delivered,
12 issued, or renewed on or after January 1, 2019 (the effective
13 date of Public Act 100-1024) or an individual policy of
14 accident and health insurance or a qualified health plan
15 offered through the health insurance marketplace amended,
16 delivered, issued, or renewed on or after January 1, 2019 (the
17 effective date of Public Act 100-1024):

18 (A) shall provide coverage based upon medical
19 necessity for the treatment of a mental, emotional,
20 nervous, or substance use disorder or condition consistent
21 with the parity requirements of Section 370c.1 of this
22 Code; provided, however, that in each calendar year
23 coverage shall not be less than the following:

24 (i) 45 days of inpatient treatment; and

25 (ii) beginning on June 26, 2006 (the effective
26 date of Public Act 94-921), 60 visits for outpatient

1 treatment including group and individual outpatient
2 treatment; and

3 (iii) for plans or policies delivered, issued for
4 delivery, renewed, or modified after January 1, 2007
5 (the effective date of Public Act 94-906), 20
6 additional outpatient visits for speech therapy for
7 treatment of pervasive developmental disorders that
8 will be in addition to speech therapy provided
9 pursuant to item (ii) of this subparagraph (A); and

10 (B) may not include a lifetime limit on the number of
11 days of inpatient treatment or the number of outpatient
12 visits covered under the plan.

13 (C) (Blank).

14 (5) An issuer of a group health benefit plan or an
15 individual policy of accident and health insurance or a
16 qualified health plan offered through the health insurance
17 marketplace may not count toward the number of outpatient
18 visits required to be covered under this Section an outpatient
19 visit for the purpose of medication management and shall cover
20 the outpatient visits under the same terms and conditions as
21 it covers outpatient visits for the treatment of physical
22 illness.

23 (5.5) An individual or group health benefit plan amended,
24 delivered, issued, or renewed on or after September 9, 2015
25 (the effective date of Public Act 99-480) shall offer coverage
26 for medically necessary acute treatment services and medically

1 necessary clinical stabilization services. The treating
2 provider shall base all treatment recommendations and the
3 health benefit plan shall base all medical necessity
4 determinations for substance use disorders in accordance with
5 the most current edition of the Treatment Criteria for
6 Addictive, Substance-Related, and Co-Occurring Conditions
7 established by the American Society of Addiction Medicine. The
8 treating provider shall base all treatment recommendations and
9 the health benefit plan shall base all medical necessity
10 determinations for medication-assisted treatment in accordance
11 with the most current Treatment Criteria for Addictive,
12 Substance-Related, and Co-Occurring Conditions established by
13 the American Society of Addiction Medicine.

14 As used in this subsection:

15 "Acute treatment services" means 24-hour medically
16 supervised addiction treatment that provides evaluation and
17 withdrawal management and may include biopsychosocial
18 assessment, individual and group counseling, psychoeducational
19 groups, and discharge planning.

20 "Clinical stabilization services" means 24-hour treatment,
21 usually following acute treatment services for substance
22 abuse, which may include intensive education and counseling
23 regarding the nature of addiction and its consequences,
24 relapse prevention, outreach to families and significant
25 others, and aftercare planning for individuals beginning to
26 engage in recovery from addiction.

1 (6) An issuer of a group health benefit plan may provide or
2 offer coverage required under this Section through a managed
3 care plan.

4 (6.5) An individual or group health benefit plan amended,
5 delivered, issued, or renewed on or after January 1, 2019 (the
6 effective date of Public Act 100-1024):

7 (A) shall not impose prior authorization requirements,
8 including limitations on dosage, other than those
9 established under the Treatment Criteria for Addictive,
10 Substance-Related, and Co-Occurring Conditions
11 established by the American Society of Addiction Medicine,
12 on a prescription medication approved by the United States
13 Food and Drug Administration that is prescribed or
14 administered for the treatment of substance use disorders;

15 (B) shall not impose any step therapy requirements,
16 other than those established under the Treatment Criteria
17 for Addictive, Substance-Related, and Co-Occurring
18 Conditions established by the American Society of
19 Addiction Medicine, before authorizing coverage for a
20 prescription medication approved by the United States Food
21 and Drug Administration that is prescribed or administered
22 for the treatment of substance use disorders;

23 (C) shall place all prescription medications approved
24 by the United States Food and Drug Administration
25 prescribed or administered for the treatment of substance
26 use disorders on, for brand medications, the lowest tier

1 of the drug formulary developed and maintained by the
2 individual or group health benefit plan that covers brand
3 medications and, for generic medications, the lowest tier
4 of the drug formulary developed and maintained by the
5 individual or group health benefit plan that covers
6 generic medications; and

7 (D) shall not exclude coverage for a prescription
8 medication approved by the United States Food and Drug
9 Administration for the treatment of substance use
10 disorders and any associated counseling or wraparound
11 services on the grounds that such medications and services
12 were court ordered.

13 (7) (Blank).

14 (8) (Blank).

15 (9) With respect to all mental, emotional, nervous, or
16 substance use disorders or conditions, coverage for inpatient
17 treatment shall include coverage for treatment in a
18 residential treatment center certified or licensed by the
19 Department of Public Health or the Department of Human
20 Services.

21 (c) This Section shall not be interpreted to require
22 coverage for speech therapy or other rehabilitative services for
23 those individuals covered under Section 356z.15 of this Code.

24 (d) With respect to a group or individual policy of
25 accident and health insurance or a qualified health plan
26 offered through the health insurance marketplace, the

1 Department and, with respect to medical assistance, the
2 Department of Healthcare and Family Services shall each
3 enforce the requirements of this Section and Sections 356z.23
4 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici
5 Mental Health Parity and Addiction Equity Act of 2008, 42
6 U.S.C. 18031(j), and any amendments to, and federal guidance
7 or regulations issued under, those Acts, including, but not
8 limited to, final regulations issued under the Paul Wellstone
9 and Pete Domenici Mental Health Parity and Addiction Equity
10 Act of 2008 and final regulations applying the Paul Wellstone
11 and Pete Domenici Mental Health Parity and Addiction Equity
12 Act of 2008 to Medicaid managed care organizations, the
13 Children's Health Insurance Program, and alternative benefit
14 plans. Specifically, the Department and the Department of
15 Healthcare and Family Services shall take action:

16 (1) proactively ensuring compliance by individual and
17 group policies, including by requiring that insurers
18 submit comparative analyses, as set forth in paragraph (6)
19 of subsection (k) of Section 370c.1, demonstrating how
20 they design and apply nonquantitative treatment
21 limitations, both as written and in operation, for mental,
22 emotional, nervous, or substance use disorder or condition
23 benefits as compared to how they design and apply
24 nonquantitative treatment limitations, as written and in
25 operation, for medical and surgical benefits;

26 (2) evaluating all consumer or provider complaints

1 regarding mental, emotional, nervous, or substance use
2 disorder or condition coverage for possible parity
3 violations;

4 (3) performing parity compliance market conduct
5 examinations or, in the case of the Department of
6 Healthcare and Family Services, parity compliance audits
7 of individual and group plans and policies, including, but
8 not limited to, reviews of:

9 (A) nonquantitative treatment limitations,
10 including, but not limited to, prior authorization
11 requirements, concurrent review, retrospective review,
12 step therapy, network admission standards,
13 reimbursement rates, and geographic restrictions;

14 (B) denials of authorization, payment, and
15 coverage; and

16 (C) other specific criteria as may be determined
17 by the Department.

18 The findings and the conclusions of the parity compliance
19 market conduct examinations and audits shall be made public.

20 The Director may adopt rules to effectuate any provisions
21 of the Paul Wellstone and Pete Domenici Mental Health Parity
22 and Addiction Equity Act of 2008 that relate to the business of
23 insurance.

24 (e) Availability of plan information.

25 (1) The criteria for medical necessity determinations
26 made under a group health plan, an individual policy of

1 accident and health insurance, or a qualified health plan
2 offered through the health insurance marketplace with
3 respect to mental health or substance use disorder
4 benefits (or health insurance coverage offered in
5 connection with the plan with respect to such benefits)
6 must be made available by the plan administrator (or the
7 health insurance issuer offering such coverage) to any
8 current or potential participant, beneficiary, or
9 contracting provider upon request.

10 (2) The reason for any denial under a group health
11 benefit plan, an individual policy of accident and health
12 insurance, or a qualified health plan offered through the
13 health insurance marketplace (or health insurance coverage
14 offered in connection with such plan or policy) of
15 reimbursement or payment for services with respect to
16 mental, emotional, nervous, or substance use disorders or
17 conditions benefits in the case of any participant or
18 beneficiary must be made available within a reasonable
19 time and in a reasonable manner and in readily
20 understandable language by the plan administrator (or the
21 health insurance issuer offering such coverage) to the
22 participant or beneficiary upon request.

23 (f) As used in this Section, "group policy of accident and
24 health insurance" and "group health benefit plan" includes (1)
25 State-regulated employer-sponsored group health insurance
26 plans written in Illinois or which purport to provide coverage

1 for a resident of this State; and (2) State employee health
2 plans.

3 (g) (1) As used in this subsection:

4 "Benefits", with respect to insurers, means the benefits
5 provided for treatment services for inpatient and outpatient
6 treatment of substance use disorders or conditions at American
7 Society of Addiction Medicine levels of treatment 2.1
8 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.1
9 (Clinically Managed Low-Intensity Residential), 3.3
10 (Clinically Managed Population-Specific High-Intensity
11 Residential), 3.5 (Clinically Managed High-Intensity
12 Residential), and 3.7 (Medically Monitored Intensive
13 Inpatient) and OMT (Opioid Maintenance Therapy) services.

14 "Benefits", with respect to managed care organizations,
15 means the benefits provided for treatment services for
16 inpatient and outpatient treatment of substance use disorders
17 or conditions at American Society of Addiction Medicine levels
18 of treatment 2.1 (Intensive Outpatient), 2.5 (Partial
19 Hospitalization), 3.5 (Clinically Managed High-Intensity
20 Residential), and 3.7 (Medically Monitored Intensive
21 Inpatient) and OMT (Opioid Maintenance Therapy) services.

22 "Substance use disorder treatment provider or facility"
23 means a licensed physician, licensed psychologist, licensed
24 psychiatrist, licensed advanced practice registered nurse, or
25 licensed, certified, or otherwise State-approved facility or
26 provider of substance use disorder treatment.

1 (2) A group health insurance policy, an individual health
2 benefit plan, or qualified health plan that is offered through
3 the health insurance marketplace, small employer group health
4 plan, and large employer group health plan that is amended,
5 delivered, issued, executed, or renewed in this State, or
6 approved for issuance or renewal in this State, on or after
7 January 1, 2019 (the effective date of Public Act 100-1023)
8 shall comply with the requirements of this Section and Section
9 370c.1. The services for the treatment and the ongoing
10 assessment of the patient's progress in treatment shall follow
11 the requirements of 77 Ill. Adm. Code 2060.

12 (3) Prior authorization shall not be utilized for the
13 benefits under this subsection. The substance use disorder
14 treatment provider or facility shall notify the insurer of the
15 initiation of treatment. For an insurer that is not a managed
16 care organization, the substance use disorder treatment
17 provider or facility notification shall occur for the
18 initiation of treatment of the covered person within 2
19 business days. For managed care organizations, the substance
20 use disorder treatment provider or facility notification shall
21 occur in accordance with the protocol set forth in the
22 provider agreement for initiation of treatment within 24
23 hours. If the managed care organization is not capable of
24 accepting the notification in accordance with the contractual
25 protocol during the 24-hour period following admission, the
26 substance use disorder treatment provider or facility shall

1 have one additional business day to provide the notification
2 to the appropriate managed care organization. Treatment plans
3 shall be developed in accordance with the requirements and
4 timeframes established in 77 Ill. Adm. Code 2060. If the
5 substance use disorder treatment provider or facility fails to
6 notify the insurer of the initiation of treatment in
7 accordance with these provisions, the insurer may follow its
8 normal prior authorization processes.

9 (4) For an insurer that is not a managed care
10 organization, if an insurer determines that benefits are no
11 longer medically necessary, the insurer shall notify the
12 covered person, the covered person's authorized
13 representative, if any, and the covered person's health care
14 provider in writing of the covered person's right to request
15 an external review pursuant to the Health Carrier External
16 Review Act. The notification shall occur within 24 hours
17 following the adverse determination.

18 Pursuant to the requirements of the Health Carrier
19 External Review Act, the covered person or the covered
20 person's authorized representative may request an expedited
21 external review. An expedited external review may not occur if
22 the substance use disorder treatment provider or facility
23 determines that continued treatment is no longer medically
24 necessary.

25 If an expedited external review request meets the criteria
26 of the Health Carrier External Review Act, an independent

1 review organization shall make a final determination of
2 medical necessity within 72 hours. If an independent review
3 organization upholds an adverse determination, an insurer
4 shall remain responsible to provide coverage of benefits
5 through the day following the determination of the independent
6 review organization. A decision to reverse an adverse
7 determination shall comply with the Health Carrier External
8 Review Act.

9 (5) The substance use disorder treatment provider or
10 facility shall provide the insurer with 7 business days'
11 advance notice of the planned discharge of the patient from
12 the substance use disorder treatment provider or facility and
13 notice on the day that the patient is discharged from the
14 substance use disorder treatment provider or facility.

15 (6) The benefits required by this subsection shall be
16 provided to all covered persons with a diagnosis of substance
17 use disorder or conditions. The presence of additional related
18 or unrelated diagnoses shall not be a basis to reduce or deny
19 the benefits required by this subsection.

20 (7) Nothing in this subsection shall be construed to
21 require an insurer to provide coverage for any of the benefits
22 in this subsection.

23 (h) As used in this Section:

24 "Generally accepted standards of mental, emotional,
25 nervous, or substance use disorder or condition care" means
26 standards of care and clinical practice that are generally

1 recognized by health care providers practicing in relevant
2 clinical specialties such as psychiatry, psychology, clinical
3 sociology, social work, addiction medicine and counseling, and
4 behavioral health treatment. Valid, evidence-based sources
5 reflecting generally accepted standards of mental, emotional,
6 nervous, or substance use disorder or condition care include
7 peer-reviewed scientific studies and medical literature,
8 recommendations of nonprofit health care provider professional
9 associations and specialty societies, including, but not
10 limited to, patient placement criteria and clinical practice
11 guidelines, recommendations of federal government agencies,
12 and drug labeling approved by the United States Food and Drug
13 Administration.

14 "Medically necessary treatment of mental, emotional,
15 nervous, or substance use disorders or conditions" means a
16 service or product addressing the specific needs of that
17 patient, for the purpose of screening, preventing, diagnosing,
18 managing, or treating an illness, injury, or condition or its
19 symptoms and comorbidities, including minimizing the
20 progression of an illness, injury, or condition or its
21 symptoms and comorbidities in a manner that is all of the
22 following:

23 (1) in accordance with the generally accepted
24 standards of mental, emotional, nervous, or substance use
25 disorder or condition care;

26 (2) clinically appropriate in terms of type,

1 frequency, extent, site, and duration; and

2 (3) not primarily for the economic benefit of the
3 insurer, purchaser, or for the convenience of the patient,
4 treating physician, or other health care provider.

5 "Utilization review" means either of the following:

6 (1) prospectively, retrospectively, or concurrently
7 reviewing and approving, modifying, delaying, or denying,
8 based in whole or in part on medical necessity, requests
9 by health care providers, insureds, or their authorized
10 representatives for coverage of health care services
11 before, retrospectively, or concurrently with the
12 provision of health care services to insureds.

13 (2) evaluating the medical necessity, appropriateness,
14 level of care, service intensity, efficacy, or efficiency
15 of health care services, benefits, procedures, or
16 settings, under any circumstances, to determine whether a
17 health care service or benefit subject to a medical
18 necessity coverage requirement in an insurance policy is
19 covered as medically necessary for an insured.

20 "Utilization review criteria" means patient placement
21 criteria or any criteria, standards, protocols, or guidelines
22 used by an insurer to conduct utilization review.

23 (i)(1) Every insurer that amends, delivers, issues, or
24 renews a group or individual policy of accident and health
25 insurance or a qualified health plan offered through the
26 health insurance marketplace in this State and Medicaid

1 managed care organizations providing coverage for hospital or
2 medical treatment on or after January 1, 2023 shall, pursuant
3 to subsections (h) through (s), provide coverage for medically
4 necessary treatment of mental, emotional, nervous, or
5 substance use disorders or conditions.

6 (2) An insurer shall not set a specific limit on the
7 duration of benefits or coverage of medically necessary
8 treatment of mental, emotional, nervous, or substance use
9 disorders or conditions or limit coverage only to alleviation
10 of the insured's current symptoms.

11 (3) All medical necessity determinations made by the
12 insurer concerning service intensity, level of care placement,
13 continued stay, and transfer or discharge of insureds
14 diagnosed with mental, emotional, nervous, or substance use
15 disorders or conditions shall be conducted in accordance with
16 the requirements of subsections (k) through (u).

17 (4) An insurer that authorizes a specific type of
18 treatment by a provider pursuant to this Section shall not
19 rescind or modify the authorization after that provider
20 renders the health care service in good faith and pursuant to
21 this authorization for any reason, including, but not limited
22 to, the insurer's subsequent cancellation or modification of
23 the insured's or policyholder's contract, or the insured's or
24 policyholder's eligibility. Nothing in this Section shall
25 require the insurer to cover a treatment when the
26 authorization was granted based on a material

1 misrepresentation by the insured, the policyholder, or the
2 provider. Nothing in this Section shall require Medicaid
3 managed care organizations to pay for services if the
4 individual was not eligible for Medicaid at the time the
5 service was rendered. Nothing in this Section shall require an
6 insurer to pay for services if the individual was not the
7 insurer's enrollee at the time services were rendered. As used
8 in this paragraph, "material" means a fact or situation that
9 is not merely technical in nature and results in or could
10 result in a substantial change in the situation.

11 (j) An insurer shall not limit benefits or coverage for
12 medically necessary services on the basis that those services
13 should be or could be covered by a public entitlement program,
14 including, but not limited to, special education or an
15 individualized education program, Medicaid, Medicare,
16 Supplemental Security Income, or Social Security Disability
17 Insurance, and shall not include or enforce a contract term
18 that excludes otherwise covered benefits on the basis that
19 those services should be or could be covered by a public
20 entitlement program. Nothing in this subsection shall be
21 construed to require an insurer to cover benefits that have
22 been authorized and provided for a covered person by a public
23 entitlement program. Medicaid managed care organizations are
24 not subject to this subsection.

25 (k) An insurer shall base any medical necessity
26 determination or the utilization review criteria that the

1 insurer, and any entity acting on the insurer's behalf,
2 applies to determine the medical necessity of health care
3 services and benefits for the diagnosis, prevention, and
4 treatment of mental, emotional, nervous, or substance use
5 disorders or conditions on current generally accepted
6 standards of mental, emotional, nervous, or substance use
7 disorder or condition care. All denials and appeals shall be
8 reviewed by a professional with experience or expertise
9 comparable to the provider requesting the authorization.

10 (1) For medical necessity determinations relating to level
11 of care placement, continued stay, and transfer or discharge
12 of insureds diagnosed with mental, emotional, and nervous
13 disorders or conditions, an insurer shall apply the patient
14 placement criteria set forth in the most recent version of the
15 treatment criteria developed by an unaffiliated nonprofit
16 professional association for the relevant clinical specialty
17 or, for Medicaid managed care organizations, patient placement
18 criteria determined by the Department of Healthcare and Family
19 Services that are consistent with generally accepted standards
20 of mental, emotional, nervous or substance use disorder or
21 condition care. Pursuant to subsection (b), in conducting
22 utilization review of all covered services and benefits for
23 the diagnosis, prevention, and treatment of substance use
24 disorders an insurer shall use the most recent edition of the
25 patient placement criteria established by the American Society
26 of Addiction Medicine.

1 (m) For medical necessity determinations relating to level
2 of care placement, continued stay, and transfer or discharge
3 that are within the scope of the sources specified in
4 subsection (l), an insurer shall not apply different,
5 additional, conflicting, or more restrictive utilization
6 review criteria than the criteria set forth in those sources.
7 For all level of care placement decisions, the insurer shall
8 authorize placement at the level of care consistent with the
9 assessment of the insured using the relevant patient placement
10 criteria as specified in subsection (l). If that level of
11 placement is not available, the insurer shall authorize the
12 next higher level of care. In the event of disagreement, the
13 insurer shall provide full detail of its assessment using the
14 relevant criteria as specified in subsection (l) to the
15 provider of the service and the patient.

16 Nothing in this subsection or subsection (l) prohibits an
17 insurer from applying utilization review criteria that were
18 developed in accordance with subsection (k) to health care
19 services and benefits for mental, emotional, and nervous
20 disorders or conditions that are not related to medical
21 necessity determinations for level of care placement,
22 continued stay, and transfer or discharge. If an insurer
23 purchases or licenses utilization review criteria pursuant to
24 this subsection, the insurer shall verify and document before
25 use that the criteria were developed in accordance with
26 subsection (k).

1 (n) In conducting utilization review that is outside the
2 scope of the criteria as specified in subsection (l) or
3 relates to the advancements in technology or in the types or
4 levels of care that are not addressed in the most recent
5 versions of the sources specified in subsection (l), an
6 insurer shall conduct utilization review in accordance with
7 subsection (k).

8 (o) This Section does not in any way limit the rights of a
9 patient under the Medical Patient Rights Act.

10 (p) This Section does not in any way limit early and
11 periodic screening, diagnostic, and treatment benefits as
12 defined under 42 U.S.C. 1396d(r).

13 (q) To ensure the proper use of the criteria described in
14 subsection (l), every insurer shall do all of the following:

15 (1) Educate the insurer's staff, including any third
16 parties contracted with the insurer to review claims,
17 conduct utilization reviews, or make medical necessity
18 determinations about the utilization review criteria.

19 (2) Make the educational program available to other
20 stakeholders, including the insurer's participating or
21 contracted providers and potential participants,
22 beneficiaries, or covered lives. The education program
23 must be provided at least once a year, in-person or
24 digitally, or recordings of the education program must be
25 made available to the aforementioned stakeholders.

26 (3) Provide, at no cost, the utilization review

1 criteria and any training material or resources to
2 providers and insured patients upon request. For
3 utilization review criteria not concerning level of care
4 placement, continued stay, and transfer or discharge used
5 by the insurer pursuant to subsection (m), the insurer may
6 place the criteria on a secure, password-protected website
7 so long as the access requirements of the website do not
8 unreasonably restrict access to insureds or their
9 providers. No restrictions shall be placed upon the
10 insured's or treating provider's access right to
11 utilization review criteria obtained under this paragraph
12 at any point in time, including before an initial request
13 for authorization.

14 (4) Track, identify, and analyze how the utilization
15 review criteria are used to certify care, deny care, and
16 support the appeals process.

17 (5) Conduct interrater reliability testing to ensure
18 consistency in utilization review decision making that
19 covers how medical necessity decisions are made; this
20 assessment shall cover all aspects of utilization review
21 as defined in subsection (h).

22 (6) Run interrater reliability reports about how the
23 clinical guidelines are used in conjunction with the
24 utilization review process and parity compliance
25 activities.

26 (7) Achieve interrater reliability pass rates of at

1 least 90% and, if this threshold is not met, immediately
2 provide for the remediation of poor interrater reliability
3 and interrater reliability testing for all new staff
4 before they can conduct utilization review without
5 supervision.

6 (8) Maintain documentation of interrater reliability
7 testing and the remediation actions taken for those with
8 pass rates lower than 90% and submit to the Department of
9 Insurance or, in the case of Medicaid managed care
10 organizations, the Department of Healthcare and Family
11 Services the testing results and a summary of remedial
12 actions as part of parity compliance reporting set forth
13 in subsection (k) of Section 370c.1.

14 (r) This Section applies to all health care services and
15 benefits for the diagnosis, prevention, and treatment of
16 mental, emotional, nervous, or substance use disorders or
17 conditions covered by an insurance policy, including
18 prescription drugs.

19 (s) This Section applies to an insurer that amends,
20 delivers, issues, or renews a group or individual policy of
21 accident and health insurance or a qualified health plan
22 offered through the health insurance marketplace in this State
23 providing coverage for hospital or medical treatment and
24 conducts utilization review as defined in this Section,
25 including Medicaid managed care organizations, and any entity
26 or contracting provider that performs utilization review or

1 utilization management functions on an insurer's behalf.

2 (t) If the Director determines that an insurer has
3 violated this Section, the Director may, after appropriate
4 notice and opportunity for hearing, by order, assess a civil
5 penalty between \$1,000 and \$5,000 for each violation. Moneys
6 collected from penalties shall be deposited into the Parity
7 Advancement Fund established in subsection (i) of Section
8 370c.1.

9 (u) An insurer shall not adopt, impose, or enforce terms
10 in its policies or provider agreements, in writing or in
11 operation, that undermine, alter, or conflict with the
12 requirements of this Section.

13 (v) The provisions of this Section are severable. If any
14 provision of this Section or its application is held invalid,
15 that invalidity shall not affect other provisions or
16 applications that can be given effect without the invalid
17 provision or application.

18 (Source: P.A. 102-558, eff. 8-20-21; 102-579, eff. 1-1-22;
19 102-813, eff. 5-13-22; 103-426, eff. 8-4-23.)

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

22 (305 ILCS 5/5-5)

23 Sec. 5-5. Medical services. The Illinois Department, by
24 rule, shall determine the quantity and quality of and the rate

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

1 and evaluation process inclusive of criteria, for children and
2 adults; for purposes of this item (13), a uniform screening,
3 assessment, and evaluation process refers to a process that
4 includes an appropriate evaluation and, as warranted, a
5 referral; "uniform" does not mean the use of a singular
6 instrument, tool, or process that all must utilize; (14)
7 transportation and such other expenses as may be necessary;
8 (15) medical treatment of sexual assault survivors, as defined
9 in Section 1a of the Sexual Assault Survivors Emergency
10 Treatment Act, for injuries sustained as a result of the
11 sexual assault, including examinations and laboratory tests to
12 discover evidence which may be used in criminal proceedings
13 arising from the sexual assault; (16) the diagnosis and
14 treatment of sickle cell anemia; (16.5) services performed by
15 a chiropractic physician licensed under the Medical Practice
16 Act of 1987 and acting within the scope of his or her license,
17 including, but not limited to, chiropractic manipulative
18 treatment; and (17) any other medical care, and any other type
19 of remedial care recognized under the laws of this State. The
20 term "any other type of remedial care" shall include nursing
21 care and nursing home service for persons who rely on
22 treatment by spiritual means alone through prayer for healing.

23 Notwithstanding any other provision of this Section, a
24 comprehensive tobacco use cessation program that includes
25 purchasing prescription drugs or prescription medical devices
26 approved by the Food and Drug Administration shall be covered

1 under the medical assistance program under this Article for
2 persons who are otherwise eligible for assistance under this
3 Article.

4 Notwithstanding any other provision of this Code,
5 reproductive health care that is otherwise legal in Illinois
6 shall be covered under the medical assistance program for
7 persons who are otherwise eligible for medical assistance
8 under this Article.

9 Notwithstanding any other provision of this Section, all
10 tobacco cessation medications approved by the United States
11 Food and Drug Administration and all individual and group
12 tobacco cessation counseling services and telephone-based
13 counseling services and tobacco cessation medications provided
14 through the Illinois Tobacco Quitline shall be covered under
15 the medical assistance program for persons who are otherwise
16 eligible for assistance under this Article. The Department
17 shall comply with all federal requirements necessary to obtain
18 federal financial participation, as specified in 42 CFR
19 433.15(b)(7), for telephone-based counseling services provided
20 through the Illinois Tobacco Quitline, including, but not
21 limited to: (i) entering into a memorandum of understanding or
22 interagency agreement with the Department of Public Health, as
23 administrator of the Illinois Tobacco Quitline; and (ii)
24 developing a cost allocation plan for Medicaid-allowable
25 Illinois Tobacco Quitline services in accordance with 45 CFR
26 95.507. The Department shall submit the memorandum of

1 understanding or interagency agreement, the cost allocation
2 plan, and all other necessary documentation to the Centers for
3 Medicare and Medicaid Services for review and approval.
4 Coverage under this paragraph shall be contingent upon federal
5 approval.

6 Notwithstanding any other provision of this Code, the
7 Illinois Department may not require, as a condition of payment
8 for any laboratory test authorized under this Article, that a
9 physician's handwritten signature appear on the laboratory
10 test order form. The Illinois Department may, however, impose
11 other appropriate requirements regarding laboratory test order
12 documentation.

13 Upon receipt of federal approval of an amendment to the
14 Illinois Title XIX State Plan for this purpose, the Department
15 shall authorize the Chicago Public Schools (CPS) to procure a
16 vendor or vendors to manufacture eyeglasses for individuals
17 enrolled in a school within the CPS system. CPS shall ensure
18 that its vendor or vendors are enrolled as providers in the
19 medical assistance program and in any capitated Medicaid
20 managed care entity (MCE) serving individuals enrolled in a
21 school within the CPS system. Under any contract procured
22 under this provision, the vendor or vendors must serve only
23 individuals enrolled in a school within the CPS system. Claims
24 for services provided by CPS's vendor or vendors to recipients
25 of benefits in the medical assistance program under this Code,
26 the Children's Health Insurance Program, or the Covering ALL

1 KIDS Health Insurance Program shall be submitted to the
2 Department or the MCE in which the individual is enrolled for
3 payment and shall be reimbursed at the Department's or the
4 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

1 On and after July 1, 2018, targeted dental services, as
2 set forth in Exhibit D of the Consent Decree entered by the
3 United States District Court for the Northern District of
4 Illinois, Eastern Division, in the matter of Memisovski v.
5 Maram, Case No. 92 C 1982, that are provided to adults under
6 the medical assistance program shall be established at no less
7 than the rates set forth in the "New Rate" column in Exhibit D
8 of the Consent Decree for targeted dental services that are
9 provided to persons under the age of 18 under the medical
10 assistance program.

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

24 On and after January 1, 2022, the Department of Healthcare
25 and Family Services shall administer and regulate a
26 school-based dental program that allows for the out-of-office

1 delivery of preventative dental services in a school setting
2 to children under 19 years of age. The Department shall
3 establish, by rule, guidelines for participation by providers
4 and set requirements for follow-up referral care based on the
5 requirements established in the Dental Office Reference Manual
6 published by the Department that establishes the requirements
7 for dentists participating in the All Kids Dental School
8 Program. Every effort shall be made by the Department when
9 developing the program requirements to consider the different
10 geographic differences of both urban and rural areas of the
11 State for initial treatment and necessary follow-up care. No
12 provider shall be charged a fee by any unit of local government
13 to participate in the school-based dental program administered
14 by the Department. Nothing in this paragraph shall be
15 construed to limit or preempt a home rule unit's or school
16 district's authority to establish, change, or administer a
17 school-based dental program in addition to, or independent of,
18 the school-based dental program administered by the
19 Department.

20 The Illinois Department, by rule, may distinguish and
21 classify the medical services to be provided only in
22 accordance with the classes of persons designated in Section
23 5-2.

24 The Department of Healthcare and Family Services must
25 provide coverage and reimbursement for amino acid-based
26 elemental formulas, regardless of delivery method, for the

1 diagnosis and treatment of (i) eosinophilic disorders and (ii)
2 short bowel syndrome when the prescribing physician has issued
3 a written order stating that the amino acid-based elemental
4 formula is medically necessary.

5 The Illinois Department shall authorize the provision of,
6 and shall authorize payment for, screening by low-dose
7 mammography for the presence of occult breast cancer for
8 individuals 35 years of age or older who are eligible for
9 medical assistance under this Article, as follows:

10 (A) A baseline mammogram for individuals 35 to 39
11 years of age.

12 (B) An annual mammogram for individuals 40 years of
13 age or older.

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

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

25 (E) A screening MRI when medically necessary, as
26 determined by a physician licensed to practice medicine in

1 all of its branches.

2 (F) A diagnostic mammogram when medically necessary,
3 as determined by a physician licensed to practice medicine
4 in all its branches, advanced practice registered nurse,
5 or physician assistant.

6 The Department shall not impose a deductible, coinsurance,
7 copayment, or any other cost-sharing requirement on the
8 coverage provided under this paragraph; except that this
9 sentence does not apply to coverage of diagnostic mammograms
10 to the extent such coverage would disqualify a high-deductible
11 health plan from eligibility for a health savings account
12 pursuant to Section 223 of the Internal Revenue Code (26
13 U.S.C. 223).

14 All screenings shall include a physical breast exam,
15 instruction on self-examination and information regarding the
16 frequency of self-examination and its value as a preventative
17 tool.

18 For purposes of this Section:

19 "Diagnostic mammogram" means a mammogram obtained using
20 diagnostic mammography.

21 "Diagnostic mammography" means a method of screening that
22 is designed to evaluate an abnormality in a breast, including
23 an abnormality seen or suspected on a screening mammogram or a
24 subjective or objective abnormality otherwise detected in the
25 breast.

26 "Low-dose mammography" means the x-ray examination of the

1 breast using equipment dedicated specifically for mammography,
2 including the x-ray tube, filter, compression device, and
3 image receptor, with an average radiation exposure delivery of
4 less than one rad per breast for 2 views of an average size
5 breast. The term also includes digital mammography and
6 includes breast tomosynthesis.

7 "Breast tomosynthesis" means a radiologic procedure that
8 involves the acquisition of projection images over the
9 stationary breast to produce cross-sectional digital
10 three-dimensional images of the breast.

11 If, at any time, the Secretary of the United States
12 Department of Health and Human Services, or its successor
13 agency, promulgates rules or regulations to be published in
14 the Federal Register or publishes a comment in the Federal
15 Register or issues an opinion, guidance, or other action that
16 would require the State, pursuant to any provision of the
17 Patient Protection and Affordable Care Act (Public Law
18 111-148), including, but not limited to, 42 U.S.C.
19 18031(d)(3)(B) or any successor provision, to defray the cost
20 of any coverage for breast tomosynthesis outlined in this
21 paragraph, then the requirement that an insurer cover breast
22 tomosynthesis is inoperative other than any such coverage
23 authorized under Section 1902 of the Social Security Act, 42
24 U.S.C. 1396a, and the State shall not assume any obligation
25 for the cost of coverage for breast tomosynthesis set forth in
26 this paragraph.

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

6 On and after January 1, 2012, providers participating in a
7 quality improvement program approved by the Department shall
8 be reimbursed for screening and diagnostic mammography at the
9 same rate as the Medicare program's rates, including the
10 increased reimbursement for digital mammography and, after
11 January 1, 2023 (the effective date of Public Act 102-1018),
12 breast tomosynthesis.

13 The Department shall convene an expert panel including
14 representatives of hospitals, free-standing mammography
15 facilities, and doctors, including radiologists, to establish
16 quality standards for mammography.

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

23 The Department shall convene an expert panel, including
24 representatives of hospitals, free-standing breast cancer
25 treatment centers, breast cancer quality organizations, and
26 doctors, including breast surgeons, reconstructive breast

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

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

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

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

25 The Department shall devise a means of case-managing or
26 patient navigation for beneficiaries diagnosed with breast

1 cancer. This program shall initially operate as a pilot
2 program in areas of the State with the highest incidence of
3 mortality related to breast cancer. At least one pilot program
4 site shall be in the metropolitan Chicago area and at least one
5 site shall be outside the metropolitan Chicago area. On or
6 after July 1, 2016, the pilot program shall be expanded to
7 include one site in western Illinois, one site in southern
8 Illinois, one site in central Illinois, and 4 sites within
9 metropolitan Chicago. An evaluation of the pilot program shall
10 be carried out measuring health outcomes and cost of care for
11 those served by the pilot program compared to similarly
12 situated patients who are not served by the pilot program.

13 The Department shall require all networks of care to
14 develop a means either internally or by contract with experts
15 in navigation and community outreach to navigate cancer
16 patients to comprehensive care in a timely fashion. The
17 Department shall require all networks of care to include
18 access for patients diagnosed with cancer to at least one
19 academic commission on cancer-accredited cancer program as an
20 in-network covered benefit.

21 The Department shall provide coverage and reimbursement
22 for a human papillomavirus (HPV) vaccine that is approved for
23 marketing by the federal Food and Drug Administration for all
24 persons between the ages of 9 and 45. Subject to federal
25 approval, the Department shall provide coverage and
26 reimbursement for a human papillomavirus (HPV) vaccine for

1 persons of the age of 46 and above who have been diagnosed with
2 cervical dysplasia with a high risk of recurrence or
3 progression. The Department shall disallow any
4 preauthorization requirements for the administration of the
5 human papillomavirus (HPV) vaccine.

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

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

25 All medical providers providing medical assistance to
26 pregnant individuals under this Code shall receive information

1 from the Department on the availability of services under any
2 program providing case management services for addicted
3 individuals, including information on appropriate referrals
4 for other social services that may be needed by addicted
5 individuals in addition to treatment for addiction.

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

14 Neither the Department of Healthcare and Family Services
15 nor the Department of Human Services shall sanction the
16 recipient solely on the basis of the recipient's substance
17 abuse.

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

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

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

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

26 (2) The Department may elect to consider and negotiate

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

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

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

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

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

1 implementation of Partnerships under this Section.

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

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

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

1 acceptance and payment of nursing home claims.

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

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

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

1 regarding medical bills paid by the Illinois Department, which
2 inquiries could indicate potential existence of claims or
3 liens for the Illinois Department.

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

13 The Department has the discretion to limit the conditional
14 enrollment period for vendors based upon the category of risk
15 of the vendor.

16 Prior to enrollment and during the conditional enrollment
17 period in the medical assistance program, all vendors shall be
18 subject to enhanced oversight, screening, and review based on
19 the risk of fraud, waste, and abuse that is posed by the
20 category of risk of the vendor. The Illinois Department shall
21 establish the procedures for oversight, screening, and review,
22 which may include, but need not be limited to: criminal and
23 financial background checks; fingerprinting; license,
24 certification, and authorization verifications; unscheduled or
25 unannounced site visits; database checks; prepayment audit
26 reviews; audits; payment caps; payment suspensions; and other

1 screening as required by federal or State law.

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

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

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

24 (2) In the case of errors attributable to the Illinois
25 Department or any of its claims processing intermediaries
26 which result in an inability to receive, process, or

1 adjudicate a claim, the 180-day period shall not begin
2 until the provider has been notified of the error.

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

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

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

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

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

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

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

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

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

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

1 take any action or acquire any products or services.

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

23 The Department shall require, by rule, all providers of
24 durable medical equipment to be accredited by an accreditation
25 organization approved by the federal Centers for Medicare and
26 Medicaid Services and recognized by the Department in order to

1 bill the Department for providing durable medical equipment to
2 recipients. No later than 15 months after the effective date
3 of the rule adopted pursuant to this paragraph, all providers
4 must meet the accreditation requirement.

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

1 similar equipment from another service provider, and that the
2 refurbished durable medical equipment equally meets the needs
3 of the recipient or enrollee. Nothing in this paragraph shall
4 be construed to limit recipient or enrollee choice to obtain
5 new durable medical equipment or place any additional prior
6 authorization conditions on enrollees of managed care
7 organizations.

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

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

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

20 The Illinois Department shall report annually to the
21 General Assembly, no later than the second Friday in April of
22 1979 and each year thereafter, in regard to:

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

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

1 (c) current rate structures and proposed changes in
2 those rate structures for the various medical vendors; and
3 (d) efforts at utilization review and control by the
4 Illinois Department.

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

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

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

26 Because kidney transplantation can be an appropriate,

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

16 Notwithstanding any other provision of this Code to the
17 contrary, on or after July 1, 2015, all FDA approved forms of
18 medication assisted treatment prescribed for the treatment of
19 alcohol dependence or treatment of opioid dependence shall be
20 covered under both fee-for-service ~~fee for service~~ and managed
21 care medical assistance programs for persons who are otherwise
22 eligible for medical assistance under this Article and shall
23 not be subject to any (1) utilization control, other than
24 those established under the American Society of Addiction
25 Medicine patient placement criteria, (2) prior authorization
26 mandate, ~~or~~ (3) lifetime restriction limit mandate, or (4)

1 limitations on dosage.

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

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

1 individuals who are not infected with HIV but who are at high
2 risk of HIV infection.

3 A federally qualified health center, as defined in Section
4 1905(1)(2)(B) of the federal Social Security Act, shall be
5 reimbursed by the Department in accordance with the federally
6 qualified health center's encounter rate for services provided
7 to medical assistance recipients that are performed by a
8 dental hygienist, as defined under the Illinois Dental
9 Practice Act, working under the general supervision of a
10 dentist and employed by a federally qualified health center.

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

18 Subject to approval by the federal Centers for Medicare
19 and Medicaid Services of a Title XIX State Plan amendment
20 electing the Program of All-Inclusive Care for the Elderly
21 (PACE) as a State Medicaid option, as provided for by Subtitle
22 I (commencing with Section 4801) of Title IV of the Balanced
23 Budget Act of 1997 (Public Law 105-33) and Part 460
24 (commencing with Section 460.2) of Subchapter E of Title 42 of
25 the Code of Federal Regulations, PACE program services shall
26 become a covered benefit of the medical assistance program,

1 subject to criteria established in accordance with all
2 applicable laws.

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

8 Notwithstanding any other provision of this Code, within
9 12 months after June 2, 2022 (the effective date of Public Act
10 102-1037) and subject to federal approval, acupuncture
11 services performed by an acupuncturist licensed under the
12 Acupuncture Practice Act who is acting within the scope of his
13 or her license shall be covered under the medical assistance
14 program. The Department shall apply for any federal waiver or
15 State Plan amendment, if required, to implement this
16 paragraph. The Department may adopt any rules, including
17 standards and criteria, necessary to implement this paragraph.

18 Notwithstanding any other provision of this Code, the
19 medical assistance program shall, subject to appropriation and
20 federal approval, reimburse hospitals for costs associated
21 with a newborn screening test for the presence of
22 metachromatic leukodystrophy, as required under the Newborn
23 Metabolic Screening Act, at a rate not less than the fee
24 charged by the Department of Public Health. The Department
25 shall seek federal approval before the implementation of the
26 newborn screening test fees by the Department of Public

1 Health.

2 Notwithstanding any other provision of this Code,
3 beginning on January 1, 2024, subject to federal approval,
4 cognitive assessment and care planning services provided to a
5 person who experiences signs or symptoms of cognitive
6 impairment, as defined by the Diagnostic and Statistical
7 Manual of Mental Disorders, Fifth Edition, shall be covered
8 under the medical assistance program for persons who are
9 otherwise eligible for medical assistance under this Article.

10 Notwithstanding any other provision of this Code,
11 medically necessary reconstructive services that are intended
12 to restore physical appearance shall be covered under the
13 medical assistance program for persons who are otherwise
14 eligible for medical assistance under this Article. As used in
15 this paragraph, "reconstructive services" means treatments
16 performed on structures of the body damaged by trauma to
17 restore physical appearance.

18 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;
19 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article
20 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,
21 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;
22 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.
23 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;
24 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.
25 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;
26 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.

1 1-1-24; revised 12-15-23.)

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