

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 356g as follows:

6 (215 ILCS 5/356g) (from Ch. 73, par. 968g)

7 (Text of Section before amendment by P.A. 99-407)

8 Sec. 356g. Mammograms; mastectomies.

9 (a) Every insurer shall provide in each group or individual  
10 policy, contract, or certificate of insurance issued or renewed  
11 for persons who are residents of this State, coverage for  
12 screening by low-dose mammography for all women 35 years of age  
13 or older for the presence of occult breast cancer within the  
14 provisions of the policy, contract, or certificate. The  
15 coverage shall be as follows:

16 (1) A baseline mammogram for women 35 to 39 years of  
17 age.

18 (2) An annual mammogram for women 40 years of age or  
19 older.

20 (3) A mammogram at the age and intervals considered  
21 medically necessary by the woman's health care provider for  
22 women under 40 years of age and having a family history of  
23 breast cancer, prior personal history of breast cancer,

1 positive genetic testing, or other risk factors.

2 (4) A comprehensive ultrasound screening of an entire  
3 breast or breasts if a mammogram demonstrates  
4 heterogeneous or dense breast tissue, when medically  
5 necessary as determined by a physician licensed to practice  
6 medicine in all of its branches.

7 (5) A screening MRI when medically necessary, as  
8 determined by a physician licensed to practice medicine in  
9 all of its branches.

10 For purposes of this Section, "low-dose mammography" means  
11 the x-ray examination of the breast using equipment dedicated  
12 specifically for mammography, including the x-ray tube,  
13 filter, compression device, and image receptor, with radiation  
14 exposure delivery of less than 1 rad per breast for 2 views of  
15 an average size breast. The term also includes digital  
16 mammography.

17 (a-5) Coverage as described by subsection (a) shall be  
18 provided at no cost to the insured and shall not be applied to  
19 an annual or lifetime maximum benefit.

20 (a-10) When health care services are available through  
21 contracted providers and a person does not comply with plan  
22 provisions specific to the use of contracted providers, the  
23 requirements of subsection (a-5) are not applicable. When a  
24 person does not comply with plan provisions specific to the use  
25 of contracted providers, plan provisions specific to the use of  
26 non-contracted providers must be applied without distinction

1 for coverage required by this Section and shall be at least as  
2 favorable as for other radiological examinations covered by the  
3 policy or contract.

4 (b) No policy of accident or health insurance that provides  
5 for the surgical procedure known as a mastectomy shall be  
6 issued, amended, delivered, or renewed in this State unless  
7 that coverage also provides for prosthetic devices or  
8 reconstructive surgery incident to the mastectomy. Coverage  
9 for breast reconstruction in connection with a mastectomy shall  
10 include:

11 (1) reconstruction of the breast upon which the  
12 mastectomy has been performed;

13 (2) surgery and reconstruction of the other breast to  
14 produce a symmetrical appearance; and

15 (3) prostheses and treatment for physical  
16 complications at all stages of mastectomy, including  
17 lymphedemas.

18 Care shall be determined in consultation with the attending  
19 physician and the patient. The offered coverage for prosthetic  
20 devices and reconstructive surgery shall be subject to the  
21 deductible and coinsurance conditions applied to the  
22 mastectomy, and all other terms and conditions applicable to  
23 other benefits. When a mastectomy is performed and there is no  
24 evidence of malignancy then the offered coverage may be limited  
25 to the provision of prosthetic devices and reconstructive  
26 surgery to within 2 years after the date of the mastectomy. As

1 used in this Section, "mastectomy" means the removal of all or  
2 part of the breast for medically necessary reasons, as  
3 determined by a licensed physician.

4 Written notice of the availability of coverage under this  
5 Section shall be delivered to the insured upon enrollment and  
6 annually thereafter. An insurer may not deny to an insured  
7 eligibility, or continued eligibility, to enroll or to renew  
8 coverage under the terms of the plan solely for the purpose of  
9 avoiding the requirements of this Section. An insurer may not  
10 penalize or reduce or limit the reimbursement of an attending  
11 provider or provide incentives (monetary or otherwise) to an  
12 attending provider to induce the provider to provide care to an  
13 insured in a manner inconsistent with this Section.

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

21 (Source: P.A. 99-433, eff. 8-21-15; revised 10-20-15.)

22 (Text of Section after amendment by P.A. 99-407)

23 Sec. 356g. Mammograms; mastectomies.

24 (a) Every insurer shall provide in each group or individual  
25 policy, contract, or certificate of insurance issued or renewed

1 for persons who are residents of this State, coverage for  
2 screening by low-dose mammography for all women 35 years of age  
3 or older for the presence of occult breast cancer within the  
4 provisions of the policy, contract, or certificate. The  
5 coverage shall be as follows:

6 (1) A baseline mammogram for women 35 to 39 years of  
7 age.

8 (2) An annual mammogram for women 40 years of age or  
9 older.

10 (3) A mammogram at the age and intervals considered  
11 medically necessary by the woman's health care provider for  
12 women under 40 years of age and having a family history of  
13 breast cancer, prior personal history of breast cancer,  
14 positive genetic testing, or other risk factors.

15 (4) A comprehensive ultrasound screening of an entire  
16 breast or breasts if a mammogram demonstrates  
17 heterogeneous or dense breast tissue, when medically  
18 necessary as determined by a physician licensed to practice  
19 medicine in all of its branches.

20 (5) A screening MRI when medically necessary, as  
21 determined by a physician licensed to practice medicine in  
22 all of its branches.

23 For purposes of this Section, "low-dose mammography" means  
24 the x-ray examination of the breast using equipment dedicated  
25 specifically for mammography, including the x-ray tube,  
26 filter, compression device, and image receptor, with radiation

1 exposure delivery of less than 1 rad per breast for 2 views of  
2 an average size breast. The term also includes digital  
3 mammography and includes breast tomosynthesis. As used in this  
4 Section, the term "breast tomosynthesis" means a radiologic  
5 procedure that involves the acquisition of projection images  
6 over the stationary breast to produce cross-sectional digital  
7 three-dimensional images of the breast.

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

23 (a-5) Coverage as described by subsection (a) shall be  
24 provided at no cost to the insured and shall not be applied to  
25 an annual or lifetime maximum benefit.

26 (a-10) When health care services are available through

1 contracted providers and a person does not comply with plan  
2 provisions specific to the use of contracted providers, the  
3 requirements of subsection (a-5) are not applicable. When a  
4 person does not comply with plan provisions specific to the use  
5 of contracted providers, plan provisions specific to the use of  
6 non-contracted providers must be applied without distinction  
7 for coverage required by this Section and shall be at least as  
8 favorable as for other radiological examinations covered by the  
9 policy or contract.

10 (b) No policy of accident or health insurance that provides  
11 for the surgical procedure known as a mastectomy shall be  
12 issued, amended, delivered, or renewed in this State unless  
13 that coverage also provides for prosthetic devices or  
14 reconstructive surgery incident to the mastectomy. Coverage  
15 for breast reconstruction in connection with a mastectomy shall  
16 include:

17 (1) reconstruction of the breast upon which the  
18 mastectomy has been performed;

19 (2) surgery and reconstruction of the other breast to  
20 produce a symmetrical appearance; and

21 (3) prostheses and treatment for physical  
22 complications at all stages of mastectomy, including  
23 lymphedemas.

24 Care shall be determined in consultation with the attending  
25 physician and the patient. The offered coverage for prosthetic  
26 devices and reconstructive surgery shall be subject to the

1 deductible and coinsurance conditions applied to the  
2 mastectomy, and all other terms and conditions applicable to  
3 other benefits. When a mastectomy is performed and there is no  
4 evidence of malignancy then the offered coverage may be limited  
5 to the provision of prosthetic devices and reconstructive  
6 surgery to within 2 years after the date of the mastectomy. As  
7 used in this Section, "mastectomy" means the removal of all or  
8 part of the breast for medically necessary reasons, as  
9 determined by a licensed physician.

10 Written notice of the availability of coverage under this  
11 Section shall be delivered to the insured upon enrollment and  
12 annually thereafter. An insurer may not deny to an insured  
13 eligibility, or continued eligibility, to enroll or to renew  
14 coverage under the terms of the plan solely for the purpose of  
15 avoiding the requirements of this Section. An insurer may not  
16 penalize or reduce or limit the reimbursement of an attending  
17 provider or provide incentives (monetary or otherwise) to an  
18 attending provider to induce the provider to provide care to an  
19 insured in a manner inconsistent with this Section.

20 (c) Rulemaking authority to implement Public Act 95-1045  
21 ~~this amendatory Act of the 95th General Assembly~~, if any, is  
22 conditioned on the rules being adopted in accordance with all  
23 provisions of the Illinois Administrative Procedure Act and all  
24 rules and procedures of the Joint Committee on Administrative  
25 Rules; any purported rule not so adopted, for whatever reason,  
26 is unauthorized.



1 (Source: P.A. 99-407 (see Section 99 of P.A. 99-407 for its  
2 effective date); 99-433, eff. 8-21-15; revised 10-20-15.)

3 Section 10. The Health Maintenance Organization Act is  
4 amended by changing Section 4-6.1 as follows:

5 (215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)

6 (Text of Section before amendment by P.A. 99-407)

7 Sec. 4-6.1. Mammograms; mastectomies.

8 (a) Every contract or evidence of coverage issued by a  
9 Health Maintenance Organization for persons who are residents  
10 of this State shall contain coverage for screening by low-dose  
11 mammography for all women 35 years of age or older for the  
12 presence of occult breast cancer. The coverage shall be as  
13 follows:

14 (1) A baseline mammogram for women 35 to 39 years of  
15 age.

16 (2) An annual mammogram for women 40 years of age or  
17 older.

18 (3) A mammogram at the age and intervals considered  
19 medically necessary by the woman's health care provider for  
20 women under 40 years of age and having a family history of  
21 breast cancer, prior personal history of breast cancer,  
22 positive genetic testing, or other risk factors.

23 (4) A comprehensive ultrasound screening of an entire  
24 breast or breasts if a mammogram demonstrates

1 heterogeneous or dense breast tissue, when medically  
2 necessary as determined by a physician licensed to practice  
3 medicine in all of its branches.

4 For purposes of this Section, "low-dose mammography" means  
5 the x-ray examination of the breast using equipment dedicated  
6 specifically for mammography, including the x-ray tube,  
7 filter, compression device, and image receptor, with radiation  
8 exposure delivery of less than 1 rad per breast for 2 views of  
9 an average size breast. The term also includes digital  
10 mammography.

11 (a-5) Coverage as described in subsection (a) shall be  
12 provided at no cost to the enrollee and shall not be applied to  
13 an annual or lifetime maximum benefit.

14 (b) No contract or evidence of coverage issued by a health  
15 maintenance organization that provides for the surgical  
16 procedure known as a mastectomy shall be issued, amended,  
17 delivered, or renewed in this State on or after the effective  
18 date of this amendatory Act of the 92nd General Assembly unless  
19 that coverage also provides for prosthetic devices or  
20 reconstructive surgery incident to the mastectomy, providing  
21 that the mastectomy is performed after the effective date of  
22 this amendatory Act. Coverage for breast reconstruction in  
23 connection with a mastectomy shall include:

24 (1) reconstruction of the breast upon which the  
25 mastectomy has been performed;

26 (2) surgery and reconstruction of the other breast to

1 produce a symmetrical appearance; and

2 (3) prostheses and treatment for physical  
3 complications at all stages of mastectomy, including  
4 lymphedemas.

5 Care shall be determined in consultation with the attending  
6 physician and the patient. The offered coverage for prosthetic  
7 devices and reconstructive surgery shall be subject to the  
8 deductible and coinsurance conditions applied to the  
9 mastectomy and all other terms and conditions applicable to  
10 other benefits. When a mastectomy is performed and there is no  
11 evidence of malignancy, then the offered coverage may be  
12 limited to the provision of prosthetic devices and  
13 reconstructive surgery to within 2 years after the date of the  
14 mastectomy. As used in this Section, "mastectomy" means the  
15 removal of all or part of the breast for medically necessary  
16 reasons, as determined by a licensed physician.

17 Written notice of the availability of coverage under this  
18 Section shall be delivered to the enrollee upon enrollment and  
19 annually thereafter. A health maintenance organization may not  
20 deny to an enrollee eligibility, or continued eligibility, to  
21 enroll or to renew coverage under the terms of the plan solely  
22 for the purpose of avoiding the requirements of this Section. A  
23 health maintenance organization may not penalize or reduce or  
24 limit the reimbursement of an attending provider or provide  
25 incentives (monetary or otherwise) to an attending provider to  
26 induce the provider to provide care to an insured in a manner

1 inconsistent with this Section.

2 (c) Rulemaking authority to implement this amendatory Act  
3 of the 95th General Assembly, if any, is conditioned on the  
4 rules being adopted in accordance with all provisions of the  
5 Illinois Administrative Procedure Act and all rules and  
6 procedures of the Joint Committee on Administrative Rules; any  
7 purported rule not so adopted, for whatever reason, is  
8 unauthorized.

9 (Source: P.A. 94-121, eff. 7-6-05; 95-431, eff. 8-24-07;  
10 95-1045, eff. 3-27-09.)

11 (Text of Section after amendment by P.A. 99-407)

12 Sec. 4-6.1. Mammograms; mastectomies.

13 (a) Every contract or evidence of coverage issued by a  
14 Health Maintenance Organization for persons who are residents  
15 of this State shall contain coverage for screening by low-dose  
16 mammography for all women 35 years of age or older for the  
17 presence of occult breast cancer. The coverage shall be as  
18 follows:

19 (1) A baseline mammogram for women 35 to 39 years of  
20 age.

21 (2) An annual mammogram for women 40 years of age or  
22 older.

23 (3) A mammogram at the age and intervals considered  
24 medically necessary by the woman's health care provider for  
25 women under 40 years of age and having a family history of

1 breast cancer, prior personal history of breast cancer,  
2 positive genetic testing, or other risk factors.

3 (4) A comprehensive ultrasound screening of an entire  
4 breast or breasts if a mammogram demonstrates  
5 heterogeneous or dense breast tissue, when medically  
6 necessary as determined by a physician licensed to practice  
7 medicine in all of its branches.

8 For purposes of this Section, "low-dose mammography" means  
9 the x-ray examination of the breast using equipment dedicated  
10 specifically for mammography, including the x-ray tube,  
11 filter, compression device, and image receptor, with radiation  
12 exposure delivery of less than 1 rad per breast for 2 views of  
13 an average size breast. The term also includes digital  
14 mammography and includes breast tomosynthesis. As used in this  
15 Section, the term "breast tomosynthesis" means a radiologic  
16 procedure that involves the acquisition of projection images  
17 over the stationary breast to produce cross-sectional digital  
18 three-dimensional images of the breast.

19 If, at any time, the Secretary of the United States  
20 Department of Health and Human Services, or its successor  
21 agency, promulgates rules or regulations to be published in the  
22 Federal Register or publishes a comment in the Federal Register  
23 or issues an opinion, guidance, or other action that would  
24 require the State, pursuant to any provision of the Patient  
25 Protection and Affordable Care Act (Public Law 111-148),  
26 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any

1 successor provision, to defray the cost of any coverage for  
2 breast tomosynthesis outlined in this subsection, then the  
3 requirement that an insurer cover breast tomosynthesis is  
4 inoperative other than any such coverage authorized under  
5 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and  
6 the State shall not assume any obligation for the cost of  
7 coverage for breast tomosynthesis set forth in this subsection.

8 (a-5) Coverage as described in subsection (a) shall be  
9 provided at no cost to the enrollee and shall not be applied to  
10 an annual or lifetime maximum benefit.

11 (b) No contract or evidence of coverage issued by a health  
12 maintenance organization that provides for the surgical  
13 procedure known as a mastectomy shall be issued, amended,  
14 delivered, or renewed in this State on or after the effective  
15 date of this amendatory Act of the 92nd General Assembly unless  
16 that coverage also provides for prosthetic devices or  
17 reconstructive surgery incident to the mastectomy, providing  
18 that the mastectomy is performed after the effective date of  
19 this amendatory Act. Coverage for breast reconstruction in  
20 connection with a mastectomy shall include:

21 (1) reconstruction of the breast upon which the  
22 mastectomy has been performed;

23 (2) surgery and reconstruction of the other breast to  
24 produce a symmetrical appearance; and

25 (3) prostheses and treatment for physical  
26 complications at all stages of mastectomy, including

1       lymphedemas.

2       Care shall be determined in consultation with the attending  
3       physician and the patient. The offered coverage for prosthetic  
4       devices and reconstructive surgery shall be subject to the  
5       deductible and coinsurance conditions applied to the  
6       mastectomy and all other terms and conditions applicable to  
7       other benefits. When a mastectomy is performed and there is no  
8       evidence of malignancy, then the offered coverage may be  
9       limited to the provision of prosthetic devices and  
10      reconstructive surgery to within 2 years after the date of the  
11      mastectomy. As used in this Section, "mastectomy" means the  
12      removal of all or part of the breast for medically necessary  
13      reasons, as determined by a licensed physician.

14      Written notice of the availability of coverage under this  
15      Section shall be delivered to the enrollee upon enrollment and  
16      annually thereafter. A health maintenance organization may not  
17      deny to an enrollee eligibility, or continued eligibility, to  
18      enroll or to renew coverage under the terms of the plan solely  
19      for the purpose of avoiding the requirements of this Section. A  
20      health maintenance organization may not penalize or reduce or  
21      limit the reimbursement of an attending provider or provide  
22      incentives (monetary or otherwise) to an attending provider to  
23      induce the provider to provide care to an insured in a manner  
24      inconsistent with this Section.

25      (c) Rulemaking authority to implement this amendatory Act  
26      of the 95th General Assembly, if any, is conditioned on the

1 rules being adopted in accordance with all provisions of the  
2 Illinois Administrative Procedure Act and all rules and  
3 procedures of the Joint Committee on Administrative Rules; any  
4 purported rule not so adopted, for whatever reason, is  
5 unauthorized.

6 (Source: P.A. 99-407 (see Section 99 of P.A. 99-407 for its  
7 effective date).)

8 Section 15. The Illinois Public Aid Code is amended by  
9 changing Section 5-5 as follows:

10 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

11 (Text of Section before amendment by P.A. 99-407)

12 Sec. 5-5. Medical services. The Illinois Department, by  
13 rule, shall determine the quantity and quality of and the rate  
14 of reimbursement for the medical assistance for which payment  
15 will be authorized, and the medical services to be provided,  
16 which may include all or part of the following: (1) inpatient  
17 hospital services; (2) outpatient hospital services; (3) other  
18 laboratory and X-ray services; (4) skilled nursing home  
19 services; (5) physicians' services whether furnished in the  
20 office, the patient's home, a hospital, a skilled nursing home,  
21 or elsewhere; (6) medical care, or any other type of remedial  
22 care furnished by licensed practitioners; (7) home health care  
23 services; (8) private duty nursing service; (9) clinic  
24 services; (10) dental services, including prevention and



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

1 discover evidence which may be used in criminal proceedings  
2 arising from the sexual assault; (16) the diagnosis and  
3 treatment of sickle cell anemia; and (17) any other medical  
4 care, and any other type of remedial care recognized under the  
5 laws of this State, but not including abortions, or induced  
6 miscarriages or premature births, unless, in the opinion of a  
7 physician, such procedures are necessary for the preservation  
8 of the life of the woman seeking such treatment, or except an  
9 induced premature birth intended to produce a live viable child  
10 and such procedure is necessary for the health of the mother or  
11 her unborn child. The Illinois Department, by rule, shall  
12 prohibit any physician from providing medical assistance to  
13 anyone eligible therefor under this Code where such physician  
14 has been found guilty of performing an abortion procedure in a  
15 wilful and wanton manner upon a woman who was not pregnant at  
16 the time such abortion procedure was performed. The term "any  
17 other type of remedial care" shall include nursing care and  
18 nursing home service for persons who rely on treatment by  
19 spiritual means alone through prayer for healing.

20 Notwithstanding any other provision of this Section, a  
21 comprehensive tobacco use cessation program that includes  
22 purchasing prescription drugs or prescription medical devices  
23 approved by the Food and Drug Administration shall be covered  
24 under the medical assistance program under this Article for  
25 persons who are otherwise eligible for assistance under this  
26 Article.

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

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

26      On and after July 1, 2012, the Department of Healthcare and

1 Family Services may provide the following services to persons  
2 eligible for assistance under this Article who are  
3 participating in education, training or employment programs  
4 operated by the Department of Human Services as successor to  
5 the Department of Public Aid:

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

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

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 assistance  
17 program. A not-for-profit health clinic shall include a public  
18 health clinic or Federally Qualified Health Center or other  
19 enrolled provider, as determined by the Department, through  
20 which dental services covered under this Section are performed.  
21 The Department shall establish a process for payment of claims  
22 for reimbursement for covered dental services rendered under  
23 this provision.

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

1       The Department of Healthcare and Family Services must  
2       provide coverage and reimbursement for amino acid-based  
3       elemental formulas, regardless of delivery method, for the  
4       diagnosis and treatment of (i) eosinophilic disorders and (ii)  
5       short bowel syndrome when the prescribing physician has issued  
6       a written order stating that the amino acid-based elemental  
7       formula is medically necessary.

8       The Illinois Department shall authorize the provision of,  
9       and shall authorize payment for, screening by low-dose  
10      mammography for the presence of occult breast cancer for women  
11      35 years of age or older who are eligible for medical  
12      assistance under this Article, as follows:

13           (A) A baseline mammogram for women 35 to 39 years of  
14      age.

15           (B) An annual mammogram for women 40 years of age or  
16      older.

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

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

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

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. For purposes of this Section, "low-dose mammography"  
8           means the x-ray examination of the breast using equipment  
9           dedicated specifically for mammography, including the x-ray  
10          tube, filter, compression device, and image receptor, with an  
11          average radiation exposure delivery of less than one rad per  
12          breast for 2 views of an average size breast. The term also  
13          includes digital mammography.

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

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

23          The Department shall convene an expert panel including  
24          representatives of hospitals, free-standing mammography  
25          facilities, and doctors, including radiologists, to establish  
26          quality standards for mammography.

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

7           The Department shall convene an expert panel, including  
8   representatives of hospitals, free standing breast cancer  
9   treatment centers, breast cancer quality organizations, and  
10   doctors, including breast surgeons, reconstructive breast  
11   surgeons, oncologists, and primary care providers to establish  
12   quality standards for breast cancer treatment.

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

20          The Department shall establish a methodology to remind  
21   women who are age-appropriate for screening mammography, but  
22   who have not received a mammogram within the previous 18  
23   months, of the importance and benefit of screening mammography.  
24   The Department shall work with experts in breast cancer  
25   outreach and patient navigation to optimize these reminders and  
26   shall establish a methodology for evaluating their

1 effectiveness and modifying the methodology based on the  
2 evaluation.

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

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

23 The Department shall require all networks of care to  
24 develop a means either internally or by contract with experts  
25 in navigation and community outreach to navigate cancer  
26 patients to comprehensive care in a timely fashion. The



1 Department shall require all networks of care to include access  
2 for patients diagnosed with cancer to at least one academic  
3 commission on cancer-accredited cancer program as an  
4 in-network covered benefit.

5 Any medical or health care provider shall immediately  
6 recommend, to any pregnant woman who is being provided prenatal  
7 services and is suspected of drug abuse or is addicted as  
8 defined in the Alcoholism and Other Drug Abuse and Dependency  
9 Act, referral to a local substance abuse treatment provider  
10 licensed by the Department of Human Services or to a licensed  
11 hospital which provides substance abuse treatment services.  
12 The Department of Healthcare and Family Services shall assure  
13 coverage for the cost of treatment of the drug abuse or  
14 addiction for pregnant recipients in accordance with the  
15 Illinois Medicaid Program in conjunction with the Department of  
16 Human Services.

17 All medical providers providing medical assistance to  
18 pregnant women under this Code shall receive information from  
19 the Department on the availability of services under the Drug  
20 Free Families with a Future or any comparable program providing  
21 case management services for addicted women, including  
22 information on appropriate referrals for other social services  
23 that may be needed by addicted women in addition to treatment  
24 for addiction.

25 The Illinois Department, in cooperation with the  
26 Departments of Human Services (as successor to the Department

1 of Alcoholism and Substance Abuse) and Public Health, through a  
2 public awareness campaign, may provide information concerning  
3 treatment for alcoholism and drug abuse and addiction, prenatal  
4 health care, and other pertinent programs directed at reducing  
5 the number of drug-affected infants born to recipients of  
6 medical assistance.

7 Neither the Department of Healthcare and Family Services  
8 nor the Department of Human Services shall sanction the  
9 recipient solely on the basis of her substance abuse.

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

19 The Illinois Department may develop and contract with  
20 Partnerships of medical providers to arrange medical services  
21 for persons eligible under Section 5-2 of this Code.  
22 Implementation of this Section may be by demonstration projects  
23 in certain geographic areas. The Partnership shall be  
24 represented by a sponsor organization. The Department, by rule,  
25 shall develop qualifications for sponsors of Partnerships.  
26 Nothing in this Section shall be construed to require that the

1 sponsor organization be a medical organization.

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

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

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

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

24 Medical providers shall be required to meet certain  
25 qualifications to participate in Partnerships to ensure the  
26 delivery of high quality medical services. These

1 qualifications shall be determined by rule of the Illinois  
2 Department and may be higher than qualifications for  
3 participation in the medical assistance program. Partnership  
4 sponsors may prescribe reasonable additional qualifications  
5 for participation by medical providers, only with the prior  
6 written approval of the Illinois Department.

7 Nothing in this Section shall limit the free choice of  
8 practitioners, hospitals, and other providers of medical  
9 services by clients. In order to ensure patient freedom of  
10 choice, the Illinois Department shall immediately promulgate  
11 all rules and take all other necessary actions so that provided  
12 services may be accessed from therapeutically certified  
13 optometrists to the full extent of the Illinois Optometric  
14 Practice Act of 1987 without discriminating between service  
15 providers.

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

19 The Illinois Department shall require health care  
20 providers to maintain records that document the medical care  
21 and services provided to recipients of Medical Assistance under  
22 this Article. Such records must be retained for a period of not  
23 less than 6 years from the date of service or as provided by  
24 applicable State law, whichever period is longer, except that  
25 if an audit is initiated within the required retention period  
26 then the records must be retained until the audit is completed

1 and every exception is resolved. The Illinois Department shall  
2 require health care providers to make available, when  
3 authorized by the patient, in writing, the medical records in a  
4 timely fashion to other health care providers who are treating  
5 or serving persons eligible for Medical Assistance under this  
6 Article. All dispensers of medical services shall be required  
7 to maintain and retain business and professional records  
8 sufficient to fully and accurately document the nature, scope,  
9 details and receipt of the health care provided to persons  
10 eligible for medical assistance under this Code, in accordance  
11 with regulations promulgated by the Illinois Department. The  
12 rules and regulations shall require that proof of the receipt  
13 of prescription drugs, dentures, prosthetic devices and  
14 eyeglasses by eligible persons under this Section accompany  
15 each claim for reimbursement submitted by the dispenser of such  
16 medical services. No such claims for reimbursement shall be  
17 approved for payment by the Illinois Department without such  
18 proof of receipt, unless the Illinois Department shall have put  
19 into effect and shall be operating a system of post-payment  
20 audit and review which shall, on a sampling basis, be deemed  
21 adequate by the Illinois Department to assure that such drugs,  
22 dentures, prosthetic devices and eyeglasses for which payment  
23 is being made are actually being received by eligible  
24 recipients. Within 90 days after September 16, 1984 (the  
25 effective date of Public Act 83-1439) ~~this amendatory Act of~~  
26 ~~1984~~, the Illinois Department shall establish a current list of

1 acquisition costs for all prosthetic devices and any other  
2 items recognized as medical equipment and supplies  
3 reimbursable under this Article and shall update such list on a  
4 quarterly basis, except that the acquisition costs of all  
5 prescription drugs shall be updated no less frequently than  
6 every 30 days as required by Section 5-5.12.

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

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

24 Notwithstanding any other law to the contrary, the Illinois  
25 Department shall, within 365 days after August 15, 2014 (the  
26 effective date of Public Act 98-963), establish procedures to

1 permit ID/DD facilities licensed under the ID/DD Community Care  
2 Act and MC/DD facilities licensed under the MC/DD Act to submit  
3 monthly billing claims for reimbursement purposes. Following  
4 development of these procedures, the Department shall have an  
5 additional 365 days to test the viability of the new system and  
6 to ensure that any necessary operational or structural changes  
7 to its information technology platforms are implemented.

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

17 The Illinois Department may require that all dispensers of  
18 medical services desiring to participate in the medical  
19 assistance program established under this Article disclose,  
20 under such terms and conditions as the Illinois Department may  
21 by rule establish, all inquiries from clients and attorneys  
22 regarding medical bills paid by the Illinois Department, which  
23 inquiries could indicate potential existence of claims or liens  
24 for the Illinois Department.

25 Enrollment of a vendor shall be subject to a provisional  
26 period and shall be conditional for one year. During the period

1 of conditional enrollment, the Department may terminate the  
2 vendor's eligibility to participate in, or may disenroll the  
3 vendor from, the medical assistance program without cause.  
4 Unless otherwise specified, such termination of eligibility or  
5 disenrollment is not subject to the Department's hearing  
6 process. However, a disenrolled vendor may reapply without  
7 penalty.

8 The Department has the discretion to limit the conditional  
9 enrollment period for vendors based upon category of risk of  
10 the vendor.

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

23 The Department shall define or specify the following: (i)  
24 by provider notice, the "category of risk of the vendor" for  
25 each type of vendor, which shall take into account the level of  
26 screening applicable to a particular category of vendor under



1 federal law and regulations; (ii) by rule or provider notice,  
2 the maximum length of the conditional enrollment period for  
3 each category of risk of the vendor; and (iii) by rule, the  
4 hearing rights, if any, afforded to a vendor in each category  
5 of risk of the vendor that is terminated or disenrolled during  
6 the conditional enrollment period.

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

14 (1) In the case of a provider whose enrollment is in  
15 process by the Illinois Department, the 180-day period  
16 shall not begin until the date on the written notice from  
17 the Illinois Department that the provider enrollment is  
18 complete.

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

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

26 (4) In the case of a provider operated by a unit of

1 local government with a population exceeding 3,000,000  
2 when local government funds finance federal participation  
3 for claims payments.

4 For claims for services rendered during a period for which  
5 a recipient received retroactive eligibility, claims must be  
6 filed within 180 days after the Department determines the  
7 applicant is eligible. For claims for which the Illinois  
8 Department is not the primary payer, claims must be submitted  
9 to the Illinois Department within 180 days after the final  
10 adjudication by the primary payer.

11 In the case of long term care facilities, within 5 days of  
12 receipt by the facility of required prescreening information,  
13 data for new admissions shall be entered into the Medical  
14 Electronic Data Interchange (MEDI) or the Recipient  
15 Eligibility Verification (REV) System or successor system, and  
16 within 15 days of receipt by the facility of required  
17 prescreening information, admission documents shall be  
18 submitted through MEDI or REV or shall be submitted directly to  
19 the Department of Human Services using required admission  
20 forms. Effective September 1, 2014, admission documents,  
21 including all prescreening information, must be submitted  
22 through MEDI or REV. Confirmation numbers assigned to an  
23 accepted transaction shall be retained by a facility to verify  
24 timely submittal. Once an admission transaction has been  
25 completed, all resubmitted claims following prior rejection  
26 are subject to receipt no later than 180 days after the

1 admission transaction has been completed.

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

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

20 The Illinois Department shall enter into agreements with  
21 State agencies and departments, and is authorized to enter into  
22 agreements with federal agencies and departments, under which  
23 such agencies and departments shall share data necessary for  
24 medical assistance program integrity functions and oversight.  
25 The Illinois Department shall develop, in cooperation with  
26 other State departments and agencies, and in compliance with

1 applicable federal laws and regulations, appropriate and  
2 effective methods to share such data. At a minimum, and to the  
3 extent necessary to provide data sharing, the Illinois  
4 Department shall enter into agreements with State agencies and  
5 departments, and is authorized to enter into agreements with  
6 federal agencies and departments, including but not limited to:  
7 the Secretary of State; the Department of Revenue; the  
8 Department of Public Health; the Department of Human Services;  
9 and the Department of Financial and Professional Regulation.

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

24 The Illinois Department shall establish policies,  
25 procedures, standards and criteria by rule for the acquisition,  
26 repair and replacement of orthotic and prosthetic devices and

1 durable medical equipment. Such rules shall provide, but not be  
2 limited to, the following services: (1) immediate repair or  
3 replacement of such devices by recipients; and (2) rental,  
4 lease, purchase or lease-purchase of durable medical equipment  
5 in a cost-effective manner, taking into consideration the  
6 recipient's medical prognosis, the extent of the recipient's  
7 needs, and the requirements and costs for maintaining such  
8 equipment. Subject to prior approval, such rules shall enable a  
9 recipient to temporarily acquire and use alternative or  
10 substitute devices or equipment pending repairs or  
11 replacements of any device or equipment previously authorized  
12 for such recipient by the Department.

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

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

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

24 The Illinois Department shall report annually to the  
25 General Assembly, no later than the second Friday in April of  
26 1979 and each year thereafter, in regard to:

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

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

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

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

9       The period covered by each report shall be the 3 years  
10    ending on the June 30 prior to the report. The report shall  
11    include suggested legislation for consideration by the General  
12    Assembly. The filing of one copy of the report with the  
13    Speaker, one copy with the Minority Leader and one copy with  
14    the Clerk of the House of Representatives, one copy with the  
15    President, one copy with the Minority Leader and one copy with  
16    the Secretary of the Senate, one copy with the Legislative  
17    Research Unit, and such additional copies with the State  
18    Government Report Distribution Center for the General Assembly  
19    as is required under paragraph (t) of Section 7 of the State  
20    Library Act shall be deemed sufficient to comply with this  
21    Section.

22       Rulemaking authority to implement Public Act 95-1045, if  
23    any, is conditioned on the rules being adopted in accordance  
24    with all provisions of the Illinois Administrative Procedure  
25    Act and all rules and procedures of the Joint Committee on  
26    Administrative Rules; any purported rule not so adopted, for

1     whatever reason, is unauthorized.

2           On and after July 1, 2012, the Department shall reduce any  
3     rate of reimbursement for services or other payments or alter  
4     any methodologies authorized by this Code to reduce any rate of  
5     reimbursement for services or other payments in accordance with  
6     Section 5-5e.

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

23           Notwithstanding any other provision of this Code to the  
24    contrary, on or after July 1, 2015, all FDA approved forms of  
25    medication assisted treatment prescribed for the treatment of  
26    alcohol dependence or treatment of opioid dependence shall be



1 covered under both fee for service and managed care medical  
2 assistance programs for persons who are otherwise eligible for  
3 medical assistance under this Article and shall not be subject  
4 to any (1) utilization control, other than those established  
5 under the American Society of Addiction Medicine patient  
6 placement criteria, (2) prior authorization mandate, or (3)  
7 lifetime restriction limit mandate.

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

20 (Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13;  
21 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff.  
22 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756,  
23 eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15;  
24 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-433, eff.  
25 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

1 (Text of Section after amendment by P.A. 99-407)

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

1 treatment of mental disorders or substance use disorders or  
2 co-occurring mental health and substance use disorders is  
3 determined using a uniform screening, assessment, and  
4 evaluation process inclusive of criteria, for children and  
5 adults; for purposes of this item (13), a uniform screening,  
6 assessment, and evaluation process refers to a process that  
7 includes an appropriate evaluation and, as warranted, a  
8 referral; "uniform" does not mean the use of a singular  
9 instrument, tool, or process that all must utilize; (14)  
10 transportation and such other expenses as may be necessary;  
11 (15) medical treatment of sexual assault survivors, as defined  
12 in Section 1a of the Sexual Assault Survivors Emergency  
13 Treatment Act, for injuries sustained as a result of the sexual  
14 assault, including examinations and laboratory tests to  
15 discover evidence which may be used in criminal proceedings  
16 arising from the sexual assault; (16) the diagnosis and  
17 treatment of sickle cell anemia; and (17) any other medical  
18 care, and any other type of remedial care recognized under the  
19 laws of this State, but not including abortions, or induced  
20 miscarriages or premature births, unless, in the opinion of a  
21 physician, such procedures are necessary for the preservation  
22 of the life of the woman seeking such treatment, or except an  
23 induced premature birth intended to produce a live viable child  
24 and such procedure is necessary for the health of the mother or  
25 her unborn child. The Illinois Department, by rule, shall  
26 prohibit any physician from providing medical assistance to

1 anyone eligible therefor under this Code where such physician  
2 has been found guilty of performing an abortion procedure in a  
3 wilful and wanton manner upon a woman who was not pregnant at  
4 the time such abortion procedure was performed. The term "any  
5 other type of remedial care" shall include nursing care and  
6 nursing home service for persons who rely on treatment by  
7 spiritual means alone through prayer for healing.

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

15 Notwithstanding any other provision of this Code, the  
16 Illinois Department may not require, as a condition of payment  
17 for any laboratory test authorized under this Article, that a  
18 physician's handwritten signature appear on the laboratory  
19 test order form. The Illinois Department may, however, impose  
20 other appropriate requirements regarding laboratory test order  
21 documentation.

22 Upon receipt of federal approval of an amendment to the  
23 Illinois Title XIX State Plan for this purpose, the Department  
24 shall authorize the Chicago Public Schools (CPS) to procure a  
25 vendor or vendors to manufacture eyeglasses for individuals  
26 enrolled in a school within the CPS system. CPS shall ensure

1 that its vendor or vendors are enrolled as providers in the  
2 medical assistance program and in any capitated Medicaid  
3 managed care entity (MCE) serving individuals enrolled in a  
4 school within the CPS system. Under any contract procured under  
5 this provision, the vendor or vendors must serve only  
6 individuals enrolled in a school within the CPS system. Claims  
7 for services provided by CPS's vendor or vendors to recipients  
8 of benefits in the medical assistance program under this Code,  
9 the Children's Health Insurance Program, or the Covering ALL  
10 KIDS Health Insurance Program shall be submitted to the  
11 Department or the MCE in which the individual is enrolled for  
12 payment and shall be reimbursed at the Department's or the  
13 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

25 Notwithstanding any other provision of this Code and  
26 subject to federal approval, the Department may adopt rules to

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

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

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

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

1           (A) A baseline mammogram for women 35 to 39 years of  
2           age.

3           (B) An annual mammogram for women 40 years of age or  
4           older.

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

10          (D) A comprehensive ultrasound screening of an entire  
11          breast or breasts if a mammogram demonstrates  
12          heterogeneous or dense breast tissue, when medically  
13          necessary as determined by a physician licensed to practice  
14          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          All screenings shall include a physical breast exam,  
19          instruction on self-examination and information regarding the  
20          frequency of self-examination and its value as a preventative  
21          tool. For purposes of this Section, "low-dose mammography"  
22          means the x-ray examination of the breast using equipment  
23          dedicated specifically for mammography, including the x-ray  
24          tube, filter, compression device, and image receptor, with an  
25          average radiation exposure delivery of less than one rad per  
26          breast for 2 views of an average size breast. The term also

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

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

25 On and after January 1, 2012, providers participating in a  
26 quality improvement program approved by the Department shall be



1 reimbursed for screening and diagnostic mammography at the same  
2 rate as the Medicare program's rates, including the increased  
3 reimbursement for digital mammography.

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

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

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

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

1       The Department shall establish a methodology to remind  
2 women who are age-appropriate for screening mammography, but  
3 who have not received a mammogram within the previous 18  
4 months, of the importance and benefit of screening mammography.  
5 The Department shall work with experts in breast cancer  
6 outreach and patient navigation to optimize these reminders and  
7 shall establish a methodology for evaluating their  
8 effectiveness and modifying the methodology based on the  
9 evaluation.

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

16       The Department shall devise a means of case-managing or  
17 patient navigation for beneficiaries diagnosed with breast  
18 cancer. This program shall initially operate as a pilot program  
19 in areas of the State with the highest incidence of mortality  
20 related to breast cancer. At least one pilot program site shall  
21 be in the metropolitan Chicago area and at least one site shall  
22 be outside the metropolitan Chicago area. On or after July 1,  
23 2016, the pilot program shall be expanded to include one site  
24 in western Illinois, one site in southern Illinois, one site in  
25 central Illinois, and 4 sites within metropolitan Chicago. An  
26 evaluation of the pilot program shall be carried out measuring

1 health outcomes and cost of care for those served by the pilot  
2 program compared to similarly situated patients who are not  
3 served by the pilot program.

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

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

24 All medical providers providing medical assistance to  
25 pregnant women under this Code shall receive information from  
26 the Department on the availability of services under the Drug

1 Free Families with a Future or any comparable program providing  
2 case management services for addicted women, including  
3 information on appropriate referrals for other social services  
4 that may be needed by addicted women in addition to treatment  
5 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 a  
9 public awareness campaign, may provide information concerning  
10 treatment for alcoholism and drug abuse and addiction, prenatal  
11 health care, and other pertinent programs directed at reducing  
12 the number of drug-affected infants born to recipients of  
13 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 her substance abuse.

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

26 The Illinois Department may develop and contract with

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

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

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

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

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

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

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

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

26      The Illinois Department shall require health care

1 providers to maintain records that document the medical care  
2 and services provided to recipients of Medical Assistance under  
3 this Article. Such records must be retained for a period of not  
4 less than 6 years from the date of service or as provided by  
5 applicable State law, whichever period is longer, except that  
6 if an audit is initiated within the required retention period  
7 then the records must be retained until the audit is completed  
8 and every exception is resolved. The Illinois Department shall  
9 require health care providers to make available, when  
10 authorized by the patient, in writing, the medical records in a  
11 timely fashion to other health care providers who are treating  
12 or serving persons eligible for Medical Assistance under this  
13 Article. All dispensers of medical services shall be required  
14 to maintain and retain business and professional records  
15 sufficient to fully and accurately document the nature, scope,  
16 details and receipt of the health care provided to persons  
17 eligible for medical assistance under this Code, in accordance  
18 with regulations promulgated by the Illinois Department. The  
19 rules and regulations shall require that proof of the receipt  
20 of prescription drugs, dentures, prosthetic devices and  
21 eyeglasses by eligible persons under this Section accompany  
22 each claim for reimbursement submitted by the dispenser of such  
23 medical services. No such claims for reimbursement shall be  
24 approved for payment by the Illinois Department without such  
25 proof of receipt, unless the Illinois Department shall have put  
26 into effect and shall be operating a system of post-payment

1 audit and review which shall, on a sampling basis, be deemed  
2 adequate by the Illinois Department to assure that such drugs,  
3 dentures, prosthetic devices and eyeglasses for which payment  
4 is being made are actually being received by eligible  
5 recipients. Within 90 days after September 16, 1984 (the  
6 effective date of Public Act 83-1439) ~~this amendatory Act of~~  
7 ~~1984~~, the Illinois Department shall establish a current list of  
8 acquisition costs for all prosthetic devices and any other  
9 items recognized as medical equipment and supplies  
10 reimbursable under this Article and shall update such list on a  
11 quarterly basis, except that the acquisition costs of all  
12 prescription drugs shall be updated no less frequently than  
13 every 30 days as required by Section 5-5.12.

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

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



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

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

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

24 The Illinois Department may require that all dispensers of  
25 medical services desiring to participate in the medical  
26 assistance program established under this Article disclose,

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

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

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

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

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

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

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

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

26 (2) In the case of errors attributable to the Illinois

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

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

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

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

18 In the case of long term care facilities, within 5 days of  
19 receipt by the facility of required prescreening information,  
20 data for new admissions shall be entered into the Medical  
21 Electronic Data Interchange (MEDI) or the Recipient  
22 Eligibility Verification (REV) System or successor system, and  
23 within 15 days of receipt by the facility of required  
24 prescreening information, admission documents shall be  
25 submitted through MEDI or REV or shall be submitted directly to  
26 the Department of Human Services using required admission

1 forms. Effective September 1, 2014, admission documents,  
2 including all prescreening information, must be submitted  
3 through MEDI or REV. Confirmation numbers assigned to an  
4 accepted transaction shall be retained by a facility to verify  
5 timely submittal. Once an admission transaction has been  
6 completed, all resubmitted claims following prior rejection  
7 are subject to receipt no later than 180 days after the  
8 admission transaction has been completed.

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

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

1       The Illinois Department shall enter into agreements with  
2       State agencies and departments, and is authorized to enter into  
3       agreements with federal agencies and departments, under which  
4       such agencies and departments shall share data necessary for  
5       medical assistance program integrity functions and oversight.  
6       The Illinois Department shall develop, in cooperation with  
7       other State departments and agencies, and in compliance with  
8       applicable federal laws and regulations, appropriate and  
9       effective methods to share such data. At a minimum, and to the  
10      extent necessary to provide data sharing, the Illinois  
11      Department shall enter into agreements with State agencies and  
12      departments, and is authorized to enter into agreements with  
13      federal agencies and departments, including but not limited to:  
14      the Secretary of State; the Department of Revenue; the  
15      Department of Public Health; the Department of Human Services;  
16      and the Department of Financial and 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 acquisition,  
7 repair and replacement of orthotic and prosthetic devices and  
8 durable medical equipment. Such rules shall provide, but not be  
9 limited to, the following services: (1) immediate repair or  
10 replacement of such devices by recipients; and (2) rental,  
11 lease, purchase or lease-purchase of durable medical equipment  
12 in a cost-effective manner, taking into consideration the  
13 recipient's medical prognosis, the extent of the recipient's  
14 needs, and the requirements and costs for maintaining such  
15 equipment. Subject to prior approval, such rules shall enable a  
16 recipient to temporarily acquire and use alternative or  
17 substitute devices or equipment pending repairs or  
18 replacements of any device or equipment previously authorized  
19 for such recipient by the Department.

20 The Department shall execute, relative to the nursing home  
21 prescreening project, written inter-agency agreements with the  
22 Department of Human Services and the Department on Aging, to  
23 effect the following: (i) intake procedures and common  
24 eligibility criteria for those persons who are receiving  
25 non-institutional services; and (ii) the establishment and  
26 development of non-institutional services in areas of the State

1 where they are not currently available or are undeveloped; and  
2 (iii) notwithstanding any other provision of law, subject to  
3 federal approval, on and after July 1, 2012, an increase in the  
4 determination of need (DON) scores from 29 to 37 for applicants  
5 for institutional and home and community-based long term care;  
6 if and only if federal approval is not granted, the Department  
7 may, in conjunction with other affected agencies, implement  
8 utilization controls or changes in benefit packages to  
9 effectuate a similar savings amount for this population; and  
10 (iv) no later than July 1, 2013, minimum level of care  
11 eligibility criteria for institutional and home and  
12 community-based long term care; and (v) no later than October  
13 1, 2013, establish procedures to permit long term care  
14 providers access to eligibility scores for individuals with an  
15 admission date who are seeking or receiving services from the  
16 long term care provider. In order to select the minimum level  
17 of care eligibility criteria, the Governor shall establish a  
18 workgroup that includes affected agency representatives and  
19 stakeholders representing the institutional and home and  
20 community-based long term care interests. This Section shall  
21 not restrict the Department from implementing lower level of  
22 care eligibility criteria for community-based services in  
23 circumstances where federal approval has been granted.

24 The Illinois Department shall develop and operate, in  
25 cooperation with other State Departments and agencies and in  
26 compliance with applicable federal laws and regulations,



1 appropriate and effective systems of health care evaluation and  
2 programs for monitoring of utilization of health care services  
3 and facilities, as it affects persons eligible for medical  
4 assistance under this Code.

5 The Illinois Department shall report annually to the  
6 General Assembly, no later than the second Friday in April of  
7 1979 and each year thereafter, in regard to:

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

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

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

14 (d) efforts at utilization review and control by the  
15 Illinois Department.

16 The period covered by each report shall be the 3 years  
17 ending on the June 30 prior to the report. The report shall  
18 include suggested legislation for consideration by the General  
19 Assembly. The filing of one copy of the report with the  
20 Speaker, one copy with the Minority Leader and one copy with  
21 the Clerk of the House of Representatives, one copy with the  
22 President, one copy with the Minority Leader and one copy with  
23 the Secretary of the Senate, one copy with the Legislative  
24 Research Unit, and such additional copies with the State  
25 Government Report Distribution Center for the General Assembly  
26 as is required under paragraph (t) of Section 7 of the State

1 Library Act shall be deemed sufficient to comply with this  
2 Section.

3 Rulemaking authority to implement Public Act 95-1045, if  
4 any, is conditioned on the rules being adopted in accordance  
5 with all provisions of the Illinois Administrative Procedure  
6 Act and all rules and procedures of the Joint Committee on  
7 Administrative Rules; any purported rule not so adopted, for  
8 whatever reason, is unauthorized.

9 On and after July 1, 2012, the Department shall reduce any  
10 rate of reimbursement for services or other payments or alter  
11 any methodologies authorized by this Code to reduce any rate of  
12 reimbursement for services or other payments in accordance with  
13 Section 5-5e.

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

1 Department to perform kidney transplantation and the services  
2 under this Section shall be limited to services associated with  
3 kidney transplantation.

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

15 On or after July 1, 2015, opioid antagonists prescribed for  
16 the treatment of an opioid overdose, including the medication  
17 product, administration devices, and any pharmacy fees related  
18 to the dispensing and administration of the opioid antagonist,  
19 shall be covered under the medical assistance program for  
20 persons who are otherwise eligible for medical assistance under  
21 this Article. As used in this Section, "opioid antagonist"  
22 means a drug that binds to opioid receptors and blocks or  
23 inhibits the effect of opioids acting on those receptors,  
24 including, but not limited to, naloxone hydrochloride or any  
25 other similarly acting drug approved by the U.S. Food and Drug  
26 Administration.

(Source: P.A. 98-104, Article 9, Section 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff. 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651, eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14; 99-78, eff. 7-20-15; 99-180, eff. 7-29-15; 99-236, eff. 8-3-15; 99-407 (see Section 99 of P.A. 99-407 for its effective date); 99-433, eff. 8-21-15; 99-480, eff. 9-9-15; revised 10-13-15.)

Section 20. "An Act concerning regulation", approved August 19, 2015, Public Act 99-407, is amended by changing Section 99 as follows:

(P.A. 99-407, Sec. 99)

Sec. 99. Effective date. This Act takes effect on July 1, 2016. ~~, if and only if on or before July 1, 2016:~~

~~(1) the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations published in the Federal Register or publishes a comment in the Federal Register:~~

~~(A) repealing, amending, or reinterpreting 45 CFR 155.170 to eliminate the State's responsibility to defray the cost of a state-mandated benefit enacted on or after January 1, 2012;~~

~~(B) requiring qualified health plans, as defined in the federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act~~

1 ~~of 2010 and any subsequent amendatory Acts, rules, or~~  
2 ~~regulations issued pursuant thereto, to cover breast~~  
3 ~~tomosynthesis as an essential health benefit; or~~  
4 ~~(C) including breast tomosynthesis as a standard as~~  
5 ~~part of the essential health benefits required of benchmark~~  
6 ~~plans under 45 CFR 156.110; or~~  
7 ~~(2) the federal Patient Protection and Affordable Care Act~~  
8 ~~is repealed by an Act of Congress or is invalidated by a~~  
9 ~~decision of the U.S. Supreme Court.~~

10 (Source: P.A. 99-407, eff. (see Section 99 of P.A. 99-407 for  
11 its effective date).)

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

19 Section 99. Effective date. This Act takes effect on July  
20 1, 2016.