

**101ST GENERAL ASSEMBLY
State of Illinois
2019 and 2020
SB0162**

Introduced 1/30/2019, by Sen. Linda Holmes

SYNOPSIS AS INTRODUCED:

55 ILCS 5/5-1069	from Ch. 34, par. 5-1069
65 ILCS 5/10-4-2	from Ch. 24, par. 10-4-2
215 ILCS 5/356g	from Ch. 73, par. 968g
215 ILCS 125/4-6.1	from Ch. 111 1/2, par. 1408.7
305 ILCS 5/5-5	from Ch. 23, par. 5-5

Amends the Counties Code, the Illinois Municipal Code, Illinois Insurance Code, the Health Maintenance Organization Act, and the Illinois Public Aid Code. In provisions concerning coverage for mammograms, provides that coverage shall also include a diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant. Makes changes to coverage for a comprehensive ultrasound screening and MRI. Effective immediately.

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FISCAL NOTE ACT MAY
APPLY

STATE MANDATES ACT MAY
REQUIRE REIMBURSEMENT

A BILL FOR

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

4 Section 5. The Counties Code is amended by changing Section
5 5-1069 as follows:

6 (55 ILCS 5/5-1069) (from Ch. 34, par. 5-1069)

7 Sec. 5-1069. Group life, health, accident, hospital, and
8 medical insurance.

9 (a) The county board of any county may arrange to provide,
10 for the benefit of employees of the county, group life, health,
11 accident, hospital, and medical insurance, or any one or any
12 combination of those types of insurance, or the county board
13 may self-insure, for the benefit of its employees, all or a
14 portion of the employees' group life, health, accident,
15 hospital, and medical insurance, or any one or any combination
16 of those types of insurance, including a combination of
17 self-insurance and other types of insurance authorized by this
18 Section, provided that the county board complies with all other
19 requirements of this Section. The insurance may include
20 provision for employees who rely on treatment by prayer or
21 spiritual means alone for healing in accordance with the tenets
22 and practice of a well recognized religious denomination. The
23 county board may provide for payment by the county of a portion

1 or all of the premium or charge for the insurance with the
2 employee paying the balance of the premium or charge, if any.
3 If the county board undertakes a plan under which the county
4 pays only a portion of the premium or charge, the county board
5 shall provide for withholding and deducting from the
6 compensation of those employees who consent to join the plan
7 the balance of the premium or charge for the insurance.

8 (b) If the county board does not provide for self-insurance
9 or for a plan under which the county pays a portion or all of
10 the premium or charge for a group insurance plan, the county

11 board may provide for withholding and deducting from the
12 compensation of those employees who consent thereto the total
13 premium or charge for any group life, health, accident,
14 hospital, and medical insurance.

15 (c) The county board may exercise the powers granted in
16 this Section only if it provides for self-insurance or, where
17 it makes arrangements to provide group insurance through an
18 insurance carrier, if the kinds of group insurance are obtained
19 from an insurance company authorized to do business in the
20 State of Illinois. The county board may enact an ordinance
21 prescribing the method of operation of the insurance program.

22 (d) If a county, including a home rule county, is a
23 self-insurer for purposes of providing health insurance
24 coverage for its employees, the insurance coverage shall
25 include screening by low-dose mammography for all women 35
26 years of age or older for the presence of occult breast cancer

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1 unless the county elects to provide mammograms itself under
2 Section 5-1069.1. The coverage shall be as follows:

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

5 (2) An annual mammogram for women 40 years of age or
6 older.

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

12 (4) For a group policy of accident and health insurance
13 that is amended, delivered, issued, or renewed on or after
14 the effective date of this amendatory Act of the 101st
15 General Assembly, a ~~A~~ comprehensive ultrasound screening
16 of an entire breast or breasts if a mammogram demonstrates
17 heterogeneous or dense breast tissue or ~~7~~ when medically
18 necessary as determined by a physician licensed to practice
19 medicine in all of its branches, advanced practice

20 registered nurse, or physician assistant.

21 (5) For a group policy of accident and health insurance
22 that is amended, delivered, issued, or renewed on or after
23 the effective date of this amendatory Act of the 101st
24 General Assembly, a diagnostic mammogram when medically
25 necessary, as determined by a physician licensed to
26 practice medicine in all its branches, advanced practice

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1 registered nurse, or physician assistant.

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

9 (d-5) Coverage as described by subsection (d) shall be
10 provided at no cost to the insured and shall not be applied to
11 an annual or lifetime maximum benefit.

12 (d-10) When health care services are available through
13 contracted providers and a person does not comply with plan
14 provisions specific to the use of contracted providers, the
15 requirements of subsection (d-5) are not applicable. When a
16 person does not comply with plan provisions specific to the use
17 of contracted providers, plan provisions specific to the use of
18 non-contracted providers must be applied without distinction
19 for coverage required by this Section and shall be at least as
20 favorable as for other radiological examinations covered by the
21 policy or contract.

22 (d-15) If a county, including a home rule county, is a
23 self-insurer for purposes of providing health insurance
24 coverage for its employees, the insurance coverage shall
25 include mastectomy coverage, which includes coverage for
26 prosthetic devices or reconstructive surgery incident to the

1 mastectomy. Coverage for breast reconstruction in connection
2 with a mastectomy shall include:

3 (1) reconstruction of the breast upon which the
4 mastectomy has been performed;

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

7 (3) prostheses and treatment for physical
8 complications at all stages of mastectomy, including
9 lymphedemas.

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

22 A county, including a home rule county, that is a
23 self-insurer for purposes of providing health insurance
24 coverage for its employees, may not penalize or reduce or limit
25 the reimbursement of an attending provider or provide
26 incentives (monetary or otherwise) to an attending provider to

1 induce the provider to provide care to an insured in a manner
2 inconsistent with this Section.

3 (d-20) The requirement that mammograms be included in
4 health insurance coverage as provided in subsections (d)
5 through (d-15) is an exclusive power and function of the State
6 and is a denial and limitation under Article VII, Section 6,
7 subsection (h) of the Illinois Constitution of home rule county

8 powers. A home rule county to which subsections (d) through
9 (d-15) apply must comply with every provision of those
10 subsections.

11 (e) The term "employees" as used in this Section includes
12 elected or appointed officials but does not include temporary
13 employees.

14 (f) The county board may, by ordinance, arrange to provide
15 group life, health, accident, hospital, and medical insurance,
16 or any one or a combination of those types of insurance, under
17 this Section to retired former employees and retired former
18 elected or appointed officials of the county.

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

26 (Source: P.A. 99-581, eff. 1-1-17; 100-513, eff. 1-1-18.)

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1 Section 10. The Illinois Municipal Code is amended by
2 changing Section 10-4-2 as follows:

3 (65 ILCS 5/10-4-2) (from Ch. 24, par. 10-4-2)

4 Sec. 10-4-2. Group insurance.

5 (a) The corporate authorities of any municipality may
6 arrange to provide, for the benefit of employees of the
7 municipality, group life, health, accident, hospital, and
8 medical insurance, or any one or any combination of those types
9 of insurance, and may arrange to provide that insurance for the
10 benefit of the spouses or dependents of those employees. The
11 insurance may include provision for employees or other insured
12 persons who rely on treatment by prayer or spiritual means
13 alone for healing in accordance with the tenets and practice of
14 a well recognized religious denomination. The corporate
15 authorities may provide for payment by the municipality of a

16 portion of the premium or charge for the insurance with the
17 employee paying the balance of the premium or charge. If the
18 corporate authorities undertake a plan under which the
19 municipality pays a portion of the premium or charge, the
20 corporate authorities shall provide for withholding and
21 deducting from the compensation of those municipal employees
22 who consent to join the plan the balance of the premium or
23 charge for the insurance.

24 (b) If the corporate authorities do not provide for a plan

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1 under which the municipality pays a portion of the premium or
2 charge for a group insurance plan, the corporate authorities
3 may provide for withholding and deducting from the compensation
4 of those employees who consent thereto the premium or charge
5 for any group life, health, accident, hospital, and medical
6 insurance.

7 (c) The corporate authorities may exercise the powers
8 granted in this Section only if the kinds of group insurance
9 are obtained from an insurance company authorized to do
10 business in the State of Illinois, or are obtained through an
11 intergovernmental joint self-insurance pool as authorized
12 under the Intergovernmental Cooperation Act. The corporate
13 authorities may enact an ordinance prescribing the method of
14 operation of the insurance program.

15 (d) If a municipality, including a home rule municipality,
16 is a self-insurer for purposes of providing health insurance
17 coverage for its employees, the insurance coverage shall
18 include screening by low-dose mammography for all women 35
19 years of age or older for the presence of occult breast cancer
20 unless the municipality elects to provide mammograms itself
21 under Section 10-4-2.1. The coverage shall be as follows:

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

24 (2) An annual mammogram for women 40 years of age or
25 older.

26 (3) A mammogram at the age and intervals considered

1 medically necessary by the woman's health care provider for
2 women under 40 years of age and having a family history of
3 breast cancer, prior personal history of breast cancer,
4 positive genetic testing, or other risk factors.

5 (4) For a group policy of accident and health insurance
6 that is amended, delivered, issued, or renewed on or after
7 the effective date of this amendatory Act of the 101st
8 General Assembly, a ~~A~~ comprehensive ultrasound screening
9 of an entire breast or breasts if a mammogram demonstrates
10 heterogeneous or dense breast tissue or ~~7~~ when medically
11 necessary as determined by a physician licensed to practice
12 medicine in all of its branches.

13 (5) For a group policy of accident and health insurance
14 that is amended, delivered, issued, or renewed on or after
15 the effective date of this amendatory Act of the 101st
16 General Assembly, a diagnostic mammogram when medically
17 necessary, as determined by a physician licensed to
18 practice medicine in all its branches, advanced practice
19 registered nurse, or physician assistant.

20 For purposes of this subsection, "low-dose mammography"
21 means the x-ray examination of the breast using equipment
22 dedicated specifically for mammography, including the x-ray
23 tube, filter, compression device, and image receptor, with an
24 average radiation exposure delivery of less than one rad per
25 breast for 2 views of an average size breast. The term also
26 includes digital mammography.

1 (d-5) Coverage as described by subsection (d) shall be
2 provided at no cost to the insured and shall not be applied to
3 an annual or lifetime maximum benefit.

4 (d-10) When health care services are available through

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

14 (d-15) If a municipality, including a home rule
15 municipality, is a self-insurer for purposes of providing
16 health insurance coverage for its employees, the insurance
17 coverage shall include mastectomy coverage, which includes
18 coverage for prosthetic devices or reconstructive surgery
19 incident to the mastectomy. Coverage for breast reconstruction
20 in 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

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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 limited
9 to the provision of prosthetic devices and reconstructive
10 surgery to within 2 years after the date of the mastectomy. As
11 used in this Section, "mastectomy" means the removal of all or
12 part of the breast for medically necessary reasons, as
13 determined by a licensed physician.

14 A municipality, including a home rule municipality, that is
15 a self-insurer for purposes of providing health insurance
16 coverage for its employees, may not penalize or reduce or limit
17 the reimbursement of an attending provider or provide
18 incentives (monetary or otherwise) to an attending provider to
19 induce the provider to provide care to an insured in a manner
20 inconsistent with this Section.

21 (d-20) The requirement that mammograms be included in
22 health insurance coverage as provided in subsections (d)
23 through (d-15) is an exclusive power and function of the State
24 and is a denial and limitation under Article VII, Section 6,
25 subsection (h) of the Illinois Constitution of home rule
26 municipality powers. A home rule municipality to which

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1 subsections (d) through (d-15) apply must comply with every
2 provision of those subsections.

3 (e) Rulemaking authority to implement Public Act 95-1045,
4 if 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 (Source: P.A. 100-863, eff. 8-14-18.)

10 Section 15. The Illinois Insurance Code is amended by
11 changing Section 356g as follows:

12 (215 ILCS 5/356g) (from Ch. 73, par. 968g)
13 Sec. 356g. Mammograms; mastectomies.

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

21 (1) A baseline mammogram for women 35 to 39 years of

22 age.

23 (2) An annual mammogram for women 40 years of age or
24 older.

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

6 (4) For an individual or group policy of accident and
7 health insurance or a managed care plan that is amended,
8 delivered, issued, or renewed on or after the effective
9 date of this amendatory Act of the 101st General Assembly,
10 a ~~A~~ comprehensive ultrasound screening and MRI of an entire
11 breast or breasts if a mammogram demonstrates
12 heterogeneous or dense breast tissue or ~~7~~ when medically
13 necessary as determined by a physician licensed to practice
14 medicine in all of its branches.

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

18 (6) For an individual or group policy of accident and
19 health insurance or a managed care plan that is amended,
20 delivered, issued, or renewed on or after the effective
21 date of this amendatory Act of the 101st General Assembly,
22 a diagnostic mammogram when medically necessary, as
23 determined by a physician licensed to practice medicine in
24 all its branches, advanced practice registered nurse, or
25 physician assistant.

26 For purposes of this Section, "low-dose mammography" means

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1 the x-ray examination of the breast using equipment dedicated

2 specifically for mammography, including the x-ray tube,
3 filter, compression device, and image receptor, with radiation
4 exposure delivery of less than 1 rad per breast for 2 views of
5 an average size breast. The term also includes digital
6 mammography and includes breast tomosynthesis. As used in this
7 Section, the term "breast tomosynthesis" means a radiologic
8 procedure that involves the acquisition of projection images
9 over the stationary breast to produce cross-sectional digital
10 three-dimensional images of the breast.

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

26 (a-5) Coverage as described by subsection (a) shall be

1 provided at no cost to the insured and shall not be applied to
2 an annual or lifetime maximum benefit.

3 (a-10) When health care services are available through
4 contracted providers and a person does not comply with plan
5 provisions specific to the use of contracted providers, the
6 requirements of subsection (a-5) are not applicable. When a
7 person does not comply with plan provisions specific to the use
8 of contracted providers, plan provisions specific to the use of
9 non-contracted providers must be applied without distinction
10 for coverage required by this Section and shall be at least as
11

favorable as for other radiological examinations covered by the policy or contract.

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

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

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

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

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

Written notice of the availability of coverage under this Section shall be delivered to the insured upon enrollment and annually thereafter. An insurer may not deny to an insured eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this Section. An insurer may not penalize or reduce or limit the reimbursement of an attending

20 provider or provide incentives (monetary or otherwise) to an
21 attending provider to induce the provider to provide care to an
22 insured in a manner inconsistent with this Section.

23 (c) Rulemaking authority to implement Public Act 95-1045,
24 if any, is conditioned on the rules being adopted in accordance
25 with all provisions of the Illinois Administrative Procedure
26 Act and all rules and procedures of the Joint Committee on

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1 Administrative Rules; any purported rule not so adopted, for
2 whatever reason, is unauthorized.

3 (Source: P.A. 99-407 (see Section 20 of P.A. 99-588 for the
4 effective date of P.A. 99-407); 99-433, eff. 8-21-15; 99-588,
5 eff. 7-20-16; 99-642, eff. 7-28-16; 100-395, eff. 1-1-18.)

6 Section 20. The Health Maintenance Organization Act is
7 amended by changing Section 4-6.1 as follows:

8 (215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)

9 Sec. 4-6.1. Mammograms; mastectomies.

10 (a) Every contract or evidence of coverage issued by a
11 Health Maintenance Organization for persons who are residents
12 of this State shall contain coverage for screening by low-dose
13 mammography for all women 35 years of age or older for the
14 presence of occult breast cancer. The coverage shall be as
15 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,
24 positive genetic testing, or other risk factors.

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1 (4) For an individual or group policy of accident and
2 health insurance or a managed care plan that is amended,
3 delivered, issued, or renewed on or after the effective
4 date of this amendatory Act of the 101st General Assembly,
5 a ~~A~~ comprehensive ultrasound screening and MRI of an entire
6 breast or breasts if a mammogram demonstrates
7 heterogeneous or dense breast tissue or ~~7~~ when medically
8 necessary as determined by a physician licensed to practice
9 medicine in all of its branches.

10 (5) For an individual or group policy of accident and
11 health insurance or a managed care plan that is amended,
12 delivered, issued, or renewed on or after the effective
13 date of this amendatory Act of the 101st General Assembly,
14 a diagnostic mammogram when medically necessary, as
15 determined by a physician licensed to practice medicine in
16 all its branches, advanced practice registered nurse, or
17 physician assistant.

18 For purposes of this Section, "low-dose mammography" means
19 the x-ray examination of the breast using equipment dedicated
20 specifically for mammography, including the x-ray tube,
21 filter, compression device, and image receptor, with radiation
22 exposure delivery of less than 1 rad per breast for 2 views of
23 an average size breast. The term also includes digital
24 mammography and includes breast tomosynthesis. As used in this
25 Section, the term "breast tomosynthesis" means a radiologic
26 procedure that involves the acquisition of projection images

1 over the stationary breast to produce cross-sectional digital
2 three-dimensional images of the breast.

3 If, at any time, the Secretary of the United States
4 Department of Health and Human Services, or its successor
5 agency, promulgates rules or regulations to be published in the
6 Federal Register or publishes a comment in the Federal Register
7 or issues an opinion, guidance, or other action that would
8

9 require the State, pursuant to any provision of the Patient
10 Protection and Affordable Care Act (Public Law 111-148),
11 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
12 successor provision, to defray the cost of any coverage for
13 breast tomosynthesis outlined in this subsection, then the
14 requirement that an insurer cover breast tomosynthesis is
15 inoperative other than any such coverage authorized under
16 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
17 the State shall not assume any obligation for the cost of
18 coverage for breast tomosynthesis set forth in this subsection.

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

22 (b) No contract or evidence of coverage issued by a health
23 maintenance organization that provides for the surgical
24 procedure known as a mastectomy shall be issued, amended,
25 delivered, or renewed in this State on or after the effective
26 date of this amendatory Act of the 92nd General Assembly unless
that coverage also provides for prosthetic devices or

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1 reconstructive surgery incident to the mastectomy, providing
2 that the mastectomy is performed after the effective date of
3 this amendatory Act. Coverage for breast reconstruction in
4 connection with a mastectomy shall include:

5 (1) reconstruction of the breast upon which the
6 mastectomy has been performed;

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

9 (3) prostheses and treatment for physical
10 complications at all stages of mastectomy, including
11 lymphedemas.

12 Care shall be determined in consultation with the attending
13 physician and the patient. The offered coverage for prosthetic
14 devices and reconstructive surgery shall be subject to the
15 deductible and coinsurance conditions applied to the
16 mastectomy and all other terms and conditions applicable to

17 other benefits. When a mastectomy is performed and there is no
18 evidence of malignancy, then the offered coverage may be
19 limited to the provision of prosthetic devices and
20 reconstructive surgery to within 2 years after the date of the
21 mastectomy. As used in this Section, "mastectomy" means the
22 removal of all or part of the breast for medically necessary
23 reasons, as determined by a licensed physician.

24 Written notice of the availability of coverage under this
25 Section shall be delivered to the enrollee upon enrollment and
26 annually thereafter. A health maintenance organization may not

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1 deny to an enrollee eligibility, or continued eligibility, to
2 enroll or to renew coverage under the terms of the plan solely
3 for the purpose of avoiding the requirements of this Section. A
4 health maintenance organization may not penalize or reduce or
5 limit the reimbursement of an attending provider or provide
6 incentives (monetary or otherwise) to an attending provider to
7 induce the provider to provide care to an insured in a manner
8 inconsistent with this Section.

9 (c) Rulemaking authority to implement this amendatory Act
10 of the 95th General Assembly, if any, is conditioned on the
11 rules being adopted in accordance with all provisions of the
12 Illinois Administrative Procedure Act and all rules and
13 procedures of the Joint Committee on Administrative Rules; any
14 purported rule not so adopted, for whatever reason, is
15 unauthorized.

16 (Source: P.A. 99-407 (see Section 20 of P.A. 99-588 for the
17 effective date of P.A. 99-407); 99-588, eff. 7-20-16; 100-395,
18 eff. 1-1-18.)

19 Section 25. The Illinois Public Aid Code is amended by
20 changing Section 5-5 and by adding Section 95 as follows:

21 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

22 Sec. 5-5. Medical services. The Illinois Department, by
23 rule, shall determine the quantity and quality of and the rate
24 of reimbursement for the medical assistance for which payment

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

1 adults; for purposes of this item (13), a uniform screening,
2 assessment, and evaluation process refers to a process that
3 includes an appropriate evaluation and, as warranted, a
4 referral; "uniform" does not mean the use of a singular
5 instrument, tool, or process that all must utilize; (14)

6 transportation and such other expenses as may be necessary;
7 (15) medical treatment of sexual assault survivors, as defined
8 in Section 1a of the Sexual Assault Survivors Emergency
9 Treatment Act, for injuries sustained as a result of the sexual
10 assault, including examinations and laboratory tests to
11 discover evidence which may be used in criminal proceedings
12 arising from the sexual assault; (16) the diagnosis and
13 treatment of sickle cell anemia; and (17) any other medical
14 care, and any other type of remedial care recognized under the
15 laws of this State. The term "any other type of remedial care"
16 shall include nursing care and nursing home service for persons
17 who rely on treatment by spiritual means alone through prayer
18 for healing.

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

26 Notwithstanding any other provision of this Code,

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1 reproductive health care that is otherwise legal in Illinois
2 shall be covered under the medical assistance program for
3 persons who are otherwise eligible for medical assistance under
4 this Article.

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

12 Upon receipt of federal approval of an amendment to the
13 Illinois Title XIX State Plan for this purpose, the Department
14 shall authorize the Chicago Public Schools (CPS) to procure a
15

16 vendor or vendors to manufacture eyeglasses for individuals
17 enrolled in a school within the CPS system. CPS shall ensure
18 that its vendor or vendors are enrolled as providers in the
19 medical assistance program and in any capitated Medicaid
20 managed care entity (MCE) serving individuals enrolled in a
21 school within the CPS system. Under any contract procured under
22 this provision, the vendor or vendors must serve only
23 individuals enrolled in a school within the CPS system. Claims
24 for services provided by CPS's vendor or vendors to recipients
25 of benefits in the medical assistance program under this Code,
26 the Children's Health Insurance Program, or the Covering ALL
KIDS Health Insurance Program shall be submitted to the

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1 Department or the MCE in which the individual is enrolled for
2 payment and shall be reimbursed at the Department's or the
3 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

24 supervision of a dentist in the practice of his or her
25 profession.

26 On and after July 1, 2018, targeted dental services, as set

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

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

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

26 The Department of Healthcare and Family Services must

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1 provide coverage and reimbursement for amino acid-based
2 elemental formulas, regardless of delivery method, for the

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

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

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

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

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

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

26 (E) A screening MRI when medically necessary, as

1 determined by a physician licensed to practice medicine in
2 all of its branches.

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

7 All screenings shall include a physical breast exam,
8 instruction on self-examination and information regarding the
9 frequency of self-examination and its value as a preventative
10 tool. For purposes of this Section, "low-dose mammography"
11 means the x-ray examination of the breast using equipment

12 dedicated specifically for mammography, including the x-ray
13 tube, filter, compression device, and image receptor, with an
14 average radiation exposure delivery of less than one rad per
15 breast for 2 views of an average size breast. The term also
16 includes digital mammography and includes breast
17 tomosynthesis. As used in this Section, the term "breast
18 tomosynthesis" means a radiologic procedure that involves the
19 acquisition of projection images over the stationary breast to
20 produce cross-sectional digital three-dimensional images of
21 the breast. If, at any time, the Secretary of the United States
22 Department of Health and Human Services, or its successor
23 agency, promulgates rules or regulations to be published in the
24 Federal Register or publishes a comment in the Federal Register
25 or issues an opinion, guidance, or other action that would
26 require the State, pursuant to any provision of the Patient

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1 Protection and Affordable Care Act (Public Law 111-148),
2 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
3 successor provision, to defray the cost of any coverage for
4 breast tomosynthesis outlined in this paragraph, then the
5 requirement that an insurer cover breast tomosynthesis is
6 inoperative other than any such coverage authorized under
7 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
8 the State shall not assume any obligation for the cost of
9 coverage for breast tomosynthesis set forth in this paragraph.

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

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

19 The Department shall convene an expert panel including
20 representatives of hospitals, free-standing mammography

21 facilities, and doctors, including radiologists, to establish
22 quality standards for mammography.

23 On and after January 1, 2017, providers participating in a
24 breast cancer treatment quality improvement program approved
25 by the Department shall be reimbursed for breast cancer
26 treatment at a rate that is no lower than 95% of the Medicare

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1 program's rates for the data elements included in the breast
2 cancer treatment quality program.

3 The Department shall convene an expert panel, including
4 representatives of hospitals, free-standing breast cancer
5 treatment centers, breast cancer quality organizations, and
6 doctors, including breast surgeons, reconstructive breast
7 surgeons, oncologists, and primary care providers to establish
8 quality standards for breast cancer treatment.

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

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

25 The Department shall establish a performance goal for
26 primary care providers with respect to their female patients

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1 over age 40 receiving an annual mammogram. This performance
2 goal shall be used to provide additional reimbursement in the
3 form of a quality performance bonus to primary care providers
4 who meet that goal.

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

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

1 Any medical or health care provider shall immediately
2 recommend, to any pregnant woman who is being provided prenatal
3 services and is suspected of having a substance use disorder as
4 defined in the Substance Use Disorder Act, referral to a local
5 substance use disorder treatment program licensed by the
6 Department of Human Services or to a licensed hospital which
7 provides substance abuse treatment services. The Department of
8 Healthcare and Family Services shall assure coverage for the
9

10 cost of treatment of the drug abuse or addiction for pregnant
11 recipients in accordance with the Illinois Medicaid Program in
12 conjunction with the Department of Human Services.

13 All medical providers providing medical assistance to
14 pregnant women under this Code shall receive information from
15 the Department on the availability of services under any
16 program providing case management services for addicted women,
17 including information on appropriate referrals for other
18 social services that may be needed by addicted women in
19 addition to treatment for addiction.

20 The Illinois Department, in cooperation with the
21 Departments of Human Services (as successor to the Department
22 of Alcoholism and Substance Abuse) and Public Health, through a
23 public awareness campaign, may provide information concerning
24 treatment for alcoholism and drug abuse and addiction, prenatal
25 health care, and other pertinent programs directed at reducing
26 the number of drug-affected infants born to recipients of
medical assistance.

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1 Neither the Department of Healthcare and Family Services
2 nor the Department of Human Services shall sanction the
3 recipient solely on the basis of her substance abuse.

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

13 The Illinois Department may develop and contract with
14 Partnerships of medical providers to arrange medical services
15 for persons eligible under Section 5-2 of this Code.
16 Implementation of this Section may be by demonstration projects
17 in certain geographic areas. The Partnership shall be
18

19 represented by a sponsor organization. The Department, by rule,
20 shall develop qualifications for sponsors of Partnerships.
21 Nothing in this Section shall be construed to require that the
22 sponsor organization be a medical organization.

23 The sponsor must negotiate formal written contracts with
24 medical providers for physician services, inpatient and
25 outpatient hospital care, home health services, treatment for
26 alcoholism and substance abuse, and other services determined
necessary by the Illinois Department by rule for delivery by

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1 Partnerships. Physician services must include prenatal and
2 obstetrical care. The Illinois Department shall reimburse
3 medical services delivered by Partnership providers to clients
4 in target areas according to provisions of this Article and the
5 Illinois Health Finance Reform Act, except that:

6 (1) Physicians participating in a Partnership and
7 providing certain services, which shall be determined by
8 the Illinois Department, to persons in areas covered by the
9 Partnership may receive an additional surcharge for such
10 services.

11 (2) The Department may elect to consider and negotiate
12 financial incentives to encourage the development of
13 Partnerships and the efficient delivery of medical care.

14 (3) Persons receiving medical services through
15 Partnerships may receive medical and case management
16 services above the level usually offered through the
17 medical assistance program.

18 Medical providers shall be required to meet certain
19 qualifications to participate in Partnerships to ensure the
20 delivery of high quality medical services. These
21 qualifications shall be determined by rule of the Illinois
22 Department and may be higher than qualifications for
23 participation in the medical assistance program. Partnership
24 sponsors may prescribe reasonable additional qualifications
25 for participation by medical providers, only with the prior
26 written approval of the Illinois Department.

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

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

13 The Illinois Department shall require health care
 14 providers to maintain records that document the medical care
 15 and services provided to recipients of Medical Assistance under
 16 this Article. Such records must be retained for a period of not
 17 less than 6 years from the date of service or as provided by
 18 applicable State law, whichever period is longer, except that
 19 if an audit is initiated within the required retention period
 20 then the records must be retained until the audit is completed
 21 and every exception is resolved. The Illinois Department shall
 22 require health care providers to make available, when
 23 authorized by the patient, in writing, the medical records in a
 24 timely fashion to other health care providers who are treating
 25 or serving persons eligible for Medical Assistance under this
 26 Article. All dispensers of medical services shall be required

1 to maintain and retain business and professional records
 2 sufficient to fully and accurately document the nature, scope,
 3 details and receipt of the health care provided to persons
 4 eligible for medical assistance under this Code, in accordance
 5 with regulations promulgated by the Illinois Department. The

6 rules and regulations shall require that proof of the receipt
7 of prescription drugs, dentures, prosthetic devices and
8 eyeglasses by eligible persons under this Section accompany
9 each claim for reimbursement submitted by the dispenser of such
10 medical services. No such claims for reimbursement shall be
11 approved for payment by the Illinois Department without such
12 proof of receipt, unless the Illinois Department shall have put
13 into effect and shall be operating a system of post-payment
14 audit and review which shall, on a sampling basis, be deemed
15 adequate by the Illinois Department to assure that such drugs,
16 dentures, prosthetic devices and eyeglasses for which payment
17 is being made are actually being received by eligible
18 recipients. Within 90 days after September 16, 1984 (the
19 effective date of Public Act 83-1439), the Illinois Department
20 shall establish a current list of acquisition costs for all
21 prosthetic devices and any other items recognized as medical
22 equipment and supplies reimbursable under this Article and
23 shall update such list on a quarterly basis, except that the
24 acquisition costs of all prescription drugs shall be updated no
25 less frequently than every 30 days as required by Section
26 5-5.12.

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1 Notwithstanding any other law to the contrary, the Illinois
2 Department shall, within 365 days after July 22, 2013 (the
3 effective date of Public Act 98-104), establish procedures to
4 permit skilled care facilities licensed under the Nursing Home
5 Care Act to submit monthly billing claims for reimbursement
6 purposes. Following development of these procedures, the
7 Department shall, by July 1, 2016, test the viability of the
8 new system and implement any necessary operational or
9 structural changes to its information technology platforms in
10 order to allow for the direct acceptance and payment of nursing
11 home claims.

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

16 permit ID/DD facilities licensed under the ID/DD Community Care
17 Act and MC/DD facilities licensed under the MC/DD Act to submit
18 monthly billing claims for reimbursement purposes. Following
19 development of these procedures, the Department shall have an
20 additional 365 days to test the viability of the new system and
21 to ensure that any necessary operational or structural changes
22 to its information technology platforms are implemented.

23 The Illinois Department shall require all dispensers of
24 medical services, other than an individual practitioner or
25 group of practitioners, desiring to participate in the Medical
26 Assistance program established under this Article to disclose
all financial, beneficial, ownership, equity, surety or other

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1 interests in any and all firms, corporations, partnerships,
2 associations, business enterprises, joint ventures, agencies,
3 institutions or other legal entities providing any form of
4 health care services in this State under this Article.

5 The Illinois Department may require that all dispensers of
6 medical services desiring to participate in the medical
7 assistance program established under this Article disclose,
8 under such terms and conditions as the Illinois Department may
9 by rule establish, all inquiries from clients and attorneys
10 regarding medical bills paid by the Illinois Department, which
11 inquiries could indicate potential existence of claims or liens
12 for the Illinois Department.

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

22 The Department has the discretion to limit the conditional
23 enrollment period for vendors based upon category of risk of
24

the vendor.

25 Prior to enrollment and during the conditional enrollment
26 period in the medical assistance program, all vendors shall be

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1 subject to enhanced oversight, screening, and review based on
2 the risk of fraud, waste, and abuse that is posed by the
3 category of risk of the vendor. The Illinois Department shall
4 establish the procedures for oversight, screening, and review,
5 which may include, but need not be limited to: criminal and
6 financial background checks; fingerprinting; license,
7 certification, and authorization verifications; unscheduled or
8 unannounced site visits; database checks; prepayment audit
9 reviews; audits; payment caps; payment suspensions; and other
10 screening as required by federal or State law.

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

21 To be eligible for payment consideration, a vendor's
22 payment claim or bill, either as an initial claim or as a
23 resubmitted claim following prior rejection, must be received
24 by the Illinois Department, or its fiscal intermediary, no
25 later than 180 days after the latest date on the claim on which
26 medical goods or services were provided, with the following

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1 exceptions:

2 (1) In the case of a provider whose enrollment is in

3 process by the Illinois Department, the 180-day period
4 shall not begin until the date on the written notice from
5 the Illinois Department that the provider enrollment is
6 complete.

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

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

14 (4) In the case of a provider operated by a unit of
15 local government with a population exceeding 3,000,000
16 when local government funds finance federal participation
17 for claims payments.

18 For claims for services rendered during a period for which
19 a recipient received retroactive eligibility, claims must be
20 filed within 180 days after the Department determines the
21 applicant is eligible. For claims for which the Illinois
22 Department is not the primary payer, claims must be submitted
23 to the Illinois Department within 180 days after the final
24 adjudication by the primary payer.

25 In the case of long term care facilities, within 45
26 calendar days of receipt by the facility of required

1 prescreening information, new admissions with associated
2 admission documents shall be submitted through the Medical
3 Electronic Data Interchange (MEDI) or the Recipient
4 Eligibility Verification (REV) System or shall be submitted
5 directly to the Department of Human Services using required
6 admission forms. Effective September 1, 2014, admission
7 documents, including all prescreening information, must be
8 submitted through MEDI or REV. Confirmation numbers assigned to
9 an accepted transaction shall be retained by a facility to
10 verify timely submittal. Once an admission transaction has been
11 completed, all resubmitted claims following prior rejection

12 are subject to receipt no later than 180 days after the
13 admission transaction has been completed.

14 Claims that are not submitted and received in compliance
15 with the foregoing requirements shall not be eligible for
16 payment under the medical assistance program, and the State
17 shall have no liability for payment of those claims.

18 To the extent consistent with applicable information and
19 privacy, security, and disclosure laws, State and federal
20 agencies and departments shall provide the Illinois Department
21 access to confidential and other information and data necessary
22 to perform eligibility and payment verifications and other
23 Illinois Department functions. This includes, but is not
24 limited to: information pertaining to licensure;
25 certification; earnings; immigration status; citizenship; wage
26 reporting; unearned and earned income; pension income;

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1 employment; supplemental security income; social security
2 numbers; National Provider Identifier (NPI) numbers; the
3 National Practitioner Data Bank (NPDB); program and agency
4 exclusions; taxpayer identification numbers; tax delinquency;
5 corporate information; and death records.

6 The Illinois Department shall enter into agreements with
7 State agencies and departments, and is authorized to enter into
8 agreements with federal agencies and departments, under which
9 such agencies and departments shall share data necessary for
10 medical assistance program integrity functions and oversight.
11 The Illinois Department shall develop, in cooperation with
12 other State departments and agencies, and in compliance with
13 applicable federal laws and regulations, appropriate and
14 effective methods to share such data. At a minimum, and to the
15 extent necessary to provide data sharing, the Illinois
16 Department shall enter into agreements with State agencies and
17 departments, and is authorized to enter into agreements with
18 federal agencies and departments, including but not limited to:
19 the Secretary of State; the Department of Revenue; the
20 Department of Public Health; the Department of Human Services;
21

and the Department of Financial and Professional Regulation.

22 Beginning in fiscal year 2013, the Illinois Department
23 shall set forth a request for information to identify the
24 benefits of a pre-payment, post-adjudication, and post-edit
25 claims system with the goals of streamlining claims processing
26 and provider reimbursement, reducing the number of pending or

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1 rejected claims, and helping to ensure a more transparent
2 adjudication process through the utilization of: (i) provider
3 data verification and provider screening technology; and (ii)
4 clinical code editing; and (iii) pre-pay, pre- or
5 post-adjudicated predictive modeling with an integrated case
6 management system with link analysis. Such a request for
7 information shall not be considered as a request for proposal
8 or as an obligation on the part of the Illinois Department to
9 take any action or acquire any products or services.

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

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1 approval and, for wheelchairs, wheelchair parts, wheelchair
2 accessories, and related seating and positioning items,
3 determine the wholesale price by methods other than actual
4 acquisition costs.

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

13 In order to promote environmental responsibility, meet the
14 needs of recipients and enrollees, and achieve significant cost
15 savings, the Department, or a managed care organization under
16 contract with the Department, may provide recipients or managed
17 care enrollees who have a prescription or Certificate of
18 Medical Necessity access to refurbished durable medical
19 equipment under this Section (excluding prosthetic and
20 orthotic devices as defined in the Orthotics, Prosthetics, and
21 Pedorthics Practice Act and complex rehabilitation technology
22 products and associated services) through the State's
23 assistive technology program's reutilization program, using
24 staff with the Assistive Technology Professional (ATP)
25 Certification if the refurbished durable medical equipment:
26 (i) is available; (ii) is less expensive, including shipping

1 costs, than new durable medical equipment of the same type;
2 (iii) is able to withstand at least 3 years of use; (iv) is
3 cleaned, disinfected, sterilized, and safe in accordance with
4 federal Food and Drug Administration regulations and guidance
5 governing the reprocessing of medical devices in health care
6 settings; and (v) equally meets the needs of the recipient or
7 enrollee. The reutilization program shall confirm that the
8 recipient or enrollee is not already in receipt of same or
9

10 similar equipment from another service provider, and that the
11 refurbished durable medical equipment equally meets the needs
12 of the recipient or enrollee. Nothing in this paragraph shall
13 be construed to limit recipient or enrollee choice to obtain
14 new durable medical equipment or place any additional prior
15 authorization conditions on enrollees of managed care
organizations.

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

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1 for institutional and home and community-based long term care;
2 if and only if federal approval is not granted, the Department
3 may, in conjunction with other affected agencies, implement
4 utilization controls or changes in benefit packages to
5 effectuate a similar savings amount for this population; and
6 (iv) no later than July 1, 2013, minimum level of care
7 eligibility criteria for institutional and home and
8 community-based long term care; and (v) no later than October
9 1, 2013, establish procedures to permit long term care
10 providers access to eligibility scores for individuals with an
11 admission date who are seeking or receiving services from the
12 long term care provider. In order to select the minimum level
13 of care eligibility criteria, the Governor shall establish a
14 workgroup that includes affected agency representatives and
15 stakeholders representing the institutional and home and
16 community-based long term care interests. This Section shall
17 not restrict the Department from implementing lower level of
18

care eligibility criteria for community-based services in
19 circumstances where federal approval has been granted.

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

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1 The Illinois Department shall report annually to the
2 General Assembly, no later than the second Friday in April of
3 1979 and each year thereafter, in regard to:

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

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

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

10 (d) efforts at utilization review and control by the
11 Illinois Department.

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

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

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

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

22 Notwithstanding any other provision of this Code to the
23 contrary, on or after July 1, 2015, all FDA approved forms of
24 medication assisted treatment prescribed for the treatment of
25 alcohol dependence or treatment of opioid dependence shall be
26 covered under both fee for service and managed care medical

1 assistance programs for persons who are otherwise eligible for
2 medical assistance under this Article and shall not be subject
3 to any (1) utilization control, other than those established
4 under the American Society of Addiction Medicine patient
5 placement criteria, (2) prior authorization mandate, or (3)

6 lifetime restriction limit mandate.

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

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

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

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

13 Notwithstanding any other provision of this Code, the
14 Illinois Department shall authorize licensed dietitian
15

16 nutritionists and certified diabetes educators to counsel
17 senior diabetes patients in the senior diabetes patients' homes
18 to remove the hurdle of transportation for senior diabetes
19 patients to receive treatment.
20 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
21 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
22 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;
23 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
24 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,
25 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
26 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff.
1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18;

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1 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff.
2 12-10-18.)

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