



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB4189

by Rep. David B. Reis

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6	from Ch. 127, par. 526
5 ILCS 375/6.1	from Ch. 127, par. 526.1
305 ILCS 5/5-5	from Ch. 23, par. 5-5
305 ILCS 5/5-8	from Ch. 23, par. 5-8
305 ILCS 5/5-9	from Ch. 23, par. 5-9
305 ILCS 5/6-1	from Ch. 23, par. 6-1
410 ILCS 230/4-100	from Ch. 111 1/2, par. 4604-100
720 ILCS 510/1	from Ch. 38, par. 81-21

Amends the State Employees Group Insurance Act of 1971, the Illinois Public Aid Code, the Problem Pregnancy Health Services and Care Act, and the Illinois Abortion Law of 1975. Restores the provisions that were amended by Public Act 100-538 to the form in which they existed before their amendment by Public Act 100-538.

LRB100 15874 KTG 30985 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning abortion.

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

4 Section 5. The State Employees Group Insurance Act of 1971
5 is amended by changing Sections 6 and 6.1 as follows:

6 (5 ILCS 375/6) (from Ch. 127, par. 526)

7 Sec. 6. Program of health benefits.

8 (a) The program of health benefits shall provide for
9 protection against the financial costs of health care expenses
10 incurred in and out of hospital including basic
11 hospital-surgical-medical coverages. The program may include,
12 but shall not be limited to, such supplemental coverages as
13 out-patient diagnostic X-ray and laboratory expenses,
14 prescription drugs, dental services, hearing evaluations,
15 hearing aids, the dispensing and fitting of hearing aids, and
16 similar group benefits as are now or may become available.
17 However, nothing in this Act shall be construed to permit the
18 non-contributory portion of any such program to include the
19 expenses of obtaining an abortion, induced miscarriage or
20 induced premature birth unless, in the opinion of a physician,
21 such procedures are necessary for the preservation of the life
22 of the woman seeking such treatment, or except an induced
23 premature birth intended to produce a live viable child and

1 such procedure is necessary for the health of the mother or the
2 unborn child. The program may also include coverage for those
3 who rely on treatment by prayer or spiritual means alone for
4 healing in accordance with the tenets and practice of a
5 recognized religious denomination.

6 The program of health benefits shall be designed by the
7 Director (1) to provide a reasonable relationship between the
8 benefits to be included and the expected distribution of
9 expenses of each such type to be incurred by the covered
10 members and dependents, (2) to specify, as covered benefits and
11 as optional benefits, the medical services of practitioners in
12 all categories licensed under the Medical Practice Act of 1987,
13 (3) to include reasonable controls, which may include
14 deductible and co-insurance provisions, applicable to some or
15 all of the benefits, or a coordination of benefits provision,
16 to prevent or minimize unnecessary utilization of the various
17 hospital, surgical and medical expenses to be provided and to
18 provide reasonable assurance of stability of the program, and
19 (4) to provide benefits to the extent possible to members
20 throughout the State, wherever located, on an equitable basis.
21 Notwithstanding any other provision of this Section or Act, for
22 all members or dependents who are eligible for benefits under
23 Social Security or the Railroad Retirement system or who had
24 sufficient Medicare-covered government employment, the
25 Department shall reduce benefits which would otherwise be paid
26 by Medicare, by the amount of benefits for which the member or

1 dependents are eligible under Medicare, except that such
2 reduction in benefits shall apply only to those members or
3 dependents who (1) first become eligible for such medicare
4 coverage on or after the effective date of this amendatory Act
5 of 1992; or (2) are Medicare-eligible members or dependents of
6 a local government unit which began participation in the
7 program on or after July 1, 1992; or (3) remain eligible for
8 but no longer receive Medicare coverage which they had been
9 receiving on or after the effective date of this amendatory Act
10 of 1992.

11 Notwithstanding any other provisions of this Act, where a
12 covered member or dependents are eligible for benefits under
13 the federal Medicare health insurance program (Title XVIII of
14 the Social Security Act as added by Public Law 89-97, 89th
15 Congress), benefits paid under the State of Illinois program or
16 plan will be reduced by the amount of benefits paid by
17 Medicare. For members or dependents who are eligible for
18 benefits under Social Security or the Railroad Retirement
19 system or who had sufficient Medicare-covered government
20 employment, benefits shall be reduced by the amount for which
21 the member or dependent is eligible under Medicare, except that
22 such reduction in benefits shall apply only to those members or
23 dependents who (1) first become eligible for such Medicare
24 coverage on or after the effective date of this amendatory Act
25 of 1992; or (2) are Medicare-eligible members or dependents of
26 a local government unit which began participation in the

1 program on or after July 1, 1992; or (3) remain eligible for,
2 but no longer receive Medicare coverage which they had been
3 receiving on or after the effective date of this amendatory Act
4 of 1992. Premiums may be adjusted, where applicable, to an
5 amount deemed by the Director to be reasonably consistent with
6 any reduction of benefits.

7 (b) A member, not otherwise covered by this Act, who has
8 retired as a participating member under Article 2 of the
9 Illinois Pension Code but is ineligible for the retirement
10 annuity under Section 2-119 of the Illinois Pension Code, shall
11 pay the premiums for coverage, not exceeding the amount paid by
12 the State for the non-contributory coverage for other members,
13 under the group health benefits program under this Act. The
14 Director shall determine the premiums to be paid by a member
15 under this subsection (b).

16 (Source: P.A. 100-538, eff. 1-1-18.)

17 (5 ILCS 375/6.1) (from Ch. 127, par. 526.1)

18 Sec. 6.1. The program of health benefits may offer as an
19 alternative, available on an optional basis, coverage through
20 health maintenance organizations. That part of the premium for
21 such coverage which is in excess of the amount which would
22 otherwise be paid by the State for the program of health
23 benefits shall be paid by the member who elects such
24 alternative coverage and shall be collected as provided for
25 premiums for other optional coverages.

1 However, nothing in this Act shall be construed to permit
2 the noncontributory portion of any such program to include the
3 expenses of obtaining an abortion, induced miscarriage or
4 induced premature birth unless, in the opinion of a physician,
5 such procedures are necessary for the preservation of the life
6 of the woman seeking such treatment, or except an induced
7 premature birth intended to produce a live viable child and
8 such procedure is necessary for the health of the mother or her
9 unborn child.

10 (Source: P.A. 100-538, eff. 1-1-18.)

11 Section 10. The Illinois Public Aid Code is amended by
12 changing Sections 5-5, 5-8, 5-9, and 6-1 as follows:

13 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

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

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

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

1 persons who are otherwise eligible for assistance under this
2 Article.

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

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

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

1 of benefits in the medical assistance program under this Code,
2 the Children's Health Insurance Program, or the Covering ALL
3 KIDS Health Insurance Program shall be submitted to the
4 Department or the MCE in which the individual is enrolled for
5 payment and shall be reimbursed at the Department's or the
6 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

18 Notwithstanding any other provision of this Code and
19 subject to federal approval, the Department may adopt rules to
20 allow a dentist who is volunteering his or her service at no
21 cost to render dental services through an enrolled
22 not-for-profit health clinic without the dentist personally
23 enrolling as a participating provider in the medical assistance
24 program. A not-for-profit health clinic shall include a public
25 health clinic or Federally Qualified Health Center or other
26 enrolled provider, as determined by the Department, through

1 which dental services covered under this Section are performed.
2 The Department shall establish a process for payment of claims
3 for reimbursement for covered dental services rendered under
4 this provision.

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

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

15 The Illinois Department shall authorize the provision of,
16 and shall authorize payment for, screening by low-dose
17 mammography for the presence of occult breast cancer for women
18 35 years of age or older who are eligible for medical
19 assistance under this Article, as follows:

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

22 (B) An annual mammogram for women 40 years of age or
23 older.

24 (C) A mammogram at the age and intervals considered
25 medically necessary by the woman's health care provider for
26 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 (D) A comprehensive ultrasound screening and MRI of an
4 entire 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 (E) A screening MRI when medically necessary, as
9 determined by a physician licensed to practice medicine in
10 all of its branches.

11 All screenings shall include a physical breast exam,
12 instruction on self-examination and information regarding the
13 frequency of self-examination and its value as a preventative
14 tool. For purposes of this Section, "low-dose mammography"
15 means the x-ray examination of the breast using equipment
16 dedicated specifically for mammography, including the x-ray
17 tube, filter, compression device, and image receptor, with an
18 average radiation exposure delivery of less than one rad per
19 breast for 2 views of an average size breast. The term also
20 includes digital mammography and includes breast
21 tomosynthesis. As used in this Section, the term "breast
22 tomosynthesis" means a radiologic procedure that involves the
23 acquisition of projection images over the stationary breast to
24 produce cross-sectional digital three-dimensional images of
25 the breast. If, at any time, the Secretary of the United States
26 Department of Health and Human Services, or its successor

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

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), the Illinois Department
26 shall establish a current list of acquisition costs for all

1 prosthetic devices and any other items recognized as medical
2 equipment and supplies reimbursable under this Article and
3 shall update such list on a quarterly basis, except that the
4 acquisition costs of all prescription drugs shall be updated no
5 less frequently than every 30 days as required by Section
6 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 45
12 calendar days of receipt by the facility of required
13 prescreening information, new admissions with associated
14 admission documents shall be submitted through the Medical
15 Electronic Data Interchange (MEDI) or the Recipient
16 Eligibility Verification (REV) System or shall be submitted
17 directly to the Department of Human Services using required
18 admission forms. Effective September 1, 2014, admission
19 documents, including all prescreening information, must be
20 submitted through MEDI or REV. Confirmation numbers assigned to
21 an accepted transaction shall be retained by a facility to
22 verify timely submittal. Once an admission transaction has been
23 completed, all resubmitted claims following prior rejection
24 are subject to receipt no later than 180 days after the
25 admission transaction has been completed.

26 Claims that are not submitted and received in compliance

1 with the foregoing requirements shall not be eligible for
2 payment under the medical assistance program, and the State
3 shall have no liability for payment of those claims.

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

18 The Illinois Department shall enter into agreements with
19 State agencies and departments, and is authorized to enter into
20 agreements with federal agencies and departments, under which
21 such agencies and departments shall share data necessary for
22 medical assistance program integrity functions and oversight.
23 The Illinois Department shall develop, in cooperation with
24 other State departments and agencies, and in compliance with
25 applicable federal laws and regulations, appropriate and
26 effective methods to share such data. At a minimum, and to the

1 extent necessary to provide data sharing, the Illinois
2 Department shall enter into agreements with State agencies and
3 departments, and is authorized to enter into agreements with
4 federal agencies and departments, including but not limited to:
5 the Secretary of State; the Department of Revenue; the
6 Department of Public Health; the Department of Human Services;
7 and the Department of Financial and Professional Regulation.

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

22 The Illinois Department shall establish policies,
23 procedures, standards and criteria by rule for the acquisition,
24 repair and replacement of orthotic and prosthetic devices and
25 durable medical equipment. Such rules shall provide, but not be
26 limited to, the following services: (1) immediate repair or

1 replacement of such devices by recipients; and (2) rental,
2 lease, purchase or lease-purchase of durable medical equipment
3 in a cost-effective manner, taking into consideration the
4 recipient's medical prognosis, the extent of the recipient's
5 needs, and the requirements and costs for maintaining such
6 equipment. Subject to prior approval, such rules shall enable a
7 recipient to temporarily acquire and use alternative or
8 substitute devices or equipment pending repairs or
9 replacements of any device or equipment previously authorized
10 for such recipient by the Department. Notwithstanding any
11 provision of Section 5-5f to the contrary, the Department may,
12 by rule, exempt certain replacement wheelchair parts from prior
13 approval and, for wheelchairs, wheelchair parts, wheelchair
14 accessories, and related seating and positioning items,
15 determine the wholesale price by methods other than actual
16 acquisition costs.

17 The Department shall require, by rule, all providers of
18 durable medical equipment to be accredited by an accreditation
19 organization approved by the federal Centers for Medicare and
20 Medicaid Services and recognized by the Department in order to
21 bill the Department for providing durable medical equipment to
22 recipients. No later than 15 months after the effective date of
23 the rule adopted pursuant to this paragraph, all providers must
24 meet the accreditation requirement.

25 The Department shall execute, relative to the nursing home
26 prescreening project, written inter-agency agreements with the

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

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

3 The Illinois Department shall develop and operate, in
4 cooperation with other State Departments and agencies and in
5 compliance with applicable federal laws and regulations,
6 appropriate and effective systems of health care evaluation and
7 programs for monitoring of utilization of health care services
8 and facilities, as it affects persons eligible for medical
9 assistance under this Code.

10 The Illinois Department shall report annually to the
11 General Assembly, no later than the second Friday in April of
12 1979 and each year thereafter, in regard to:

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

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

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

19 (d) efforts at utilization review and control by the
20 Illinois Department.

21 The period covered by each report shall be the 3 years
22 ending on the June 30 prior to the report. The report shall
23 include suggested legislation for consideration by the General
24 Assembly. The filing of one copy of the report with the
25 Speaker, one copy with the Minority Leader and one copy with
26 the Clerk of the House of Representatives, one copy with the

1 President, one copy with the Minority Leader and one copy with
2 the Secretary of the Senate, one copy with the Legislative
3 Research Unit, and such additional copies with the State
4 Government Report Distribution Center for the General Assembly
5 as is required under paragraph (t) of Section 7 of the State
6 Library Act shall be deemed sufficient to comply with this
7 Section.

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

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

19 Because kidney transplantation can be an appropriate, cost
20 effective alternative to renal dialysis when medically
21 necessary and notwithstanding the provisions of Section 1-11 of
22 this Code, beginning October 1, 2014, the Department shall
23 cover kidney transplantation for noncitizens with end-stage
24 renal disease who are not eligible for comprehensive medical
25 benefits, who meet the residency requirements of Section 5-3 of
26 this Code, and who would otherwise meet the financial

1 requirements of the appropriate class of eligible persons under
2 Section 5-2 of this Code. To qualify for coverage of kidney
3 transplantation, such person must be receiving emergency renal
4 dialysis services covered by the Department. Providers under
5 this Section shall be prior approved and certified by the
6 Department to perform kidney transplantation and the services
7 under this Section shall be limited to services associated with
8 kidney transplantation.

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

20 On or after July 1, 2015, opioid antagonists prescribed for
21 the treatment of an opioid overdose, including the medication
22 product, administration devices, and any pharmacy fees related
23 to the dispensing and administration of the opioid antagonist,
24 shall be covered under the medical assistance program for
25 persons who are otherwise eligible for medical assistance under
26 this Article. As used in this Section, "opioid antagonist"

1 means a drug that binds to opioid receptors and blocks or
2 inhibits the effect of opioids acting on those receptors,
3 including, but not limited to, naloxone hydrochloride or any
4 other similarly acting drug approved by the U.S. Food and Drug
5 Administration.

6 Upon federal approval, the Department shall provide
7 coverage and reimbursement for all drugs that are approved for
8 marketing by the federal Food and Drug Administration and that
9 are recommended by the federal Public Health Service or the
10 United States Centers for Disease Control and Prevention for
11 pre-exposure prophylaxis and related pre-exposure prophylaxis
12 services, including, but not limited to, HIV and sexually
13 transmitted infection screening, treatment for sexually
14 transmitted infections, medical monitoring, assorted labs, and
15 counseling to reduce the likelihood of HIV infection among
16 individuals who are not infected with HIV but who are at high
17 risk of HIV infection.

18 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
19 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
20 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;
21 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
22 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,
23 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
24 100-538, eff. 1-1-18; revised 10-26-17.)

25 (305 ILCS 5/5-8) (from Ch. 23, par. 5-8)

1 Sec. 5-8. Practitioners. In supplying medical assistance,
2 the Illinois Department may provide for the legally authorized
3 services of (i) persons licensed under the Medical Practice Act
4 of 1987, as amended, except as hereafter in this Section
5 stated, whether under a general or limited license, (ii)
6 persons licensed under the Nurse Practice Act as advanced
7 practice registered nurses, regardless of whether or not the
8 persons have written collaborative agreements, (iii) persons
9 licensed or registered under other laws of this State to
10 provide dental, medical, pharmaceutical, optometric,
11 podiatric, or nursing services, or other remedial care
12 recognized under State law, (iv) persons licensed under other
13 laws of this State as a clinical social worker, and (v) persons
14 licensed under other laws of this State as physician
15 assistants. The Department shall adopt rules, no later than 90
16 days after January 1, 2017 (the effective date of Public Act
17 99-621) ~~this amendatory Act of the 99th General Assembly~~, for
18 the legally authorized services of persons licensed under other
19 laws of this State as a clinical social worker. The Department
20 may not provide for legally authorized services of any
21 physician who has been convicted of having performed an
22 abortion procedure in a wilful and wanton manner on a woman who
23 was not pregnant at the time such abortion procedure was
24 performed. The utilization of the services of persons engaged
25 in the treatment or care of the sick, which persons are not
26 required to be licensed or registered under the laws of this

1 State, is not prohibited by this Section.

2 (Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17;
3 100-453, eff. 8-25-17; 100-513, eff. 1-1-18; 100-538, eff.
4 1-1-18; revised 10-26-17.)

5 (305 ILCS 5/5-9) (from Ch. 23, par. 5-9)

6 Sec. 5-9. Choice of Medical Dispensers. Applicants and
7 recipients shall be entitled to free choice of those qualified
8 practitioners, hospitals, nursing homes, and other dispensers
9 of medical services meeting the requirements and complying with
10 the rules and regulations of the Illinois Department. However,
11 the Director of Healthcare and Family Services may, after
12 providing reasonable notice and opportunity for hearing, deny,
13 suspend or terminate any otherwise qualified person, firm,
14 corporation, association, agency, institution, or other legal
15 entity, from participation as a vendor of goods or services
16 under the medical assistance program authorized by this Article
17 if the Director finds such vendor of medical services in
18 violation of this Act or the policy or rules and regulations
19 issued pursuant to this Act. Any physician who has been
20 convicted of performing an abortion procedure in a wilful and
21 wanton manner upon a woman who was not pregnant at the time
22 such abortion procedure was performed shall be automatically
23 removed from the list of physicians qualified to participate as
24 a vendor of medical services under the medical assistance
25 program authorized by this Article.

1 (Source: P.A. 100-538, eff. 1-1-18.)

2 (305 ILCS 5/6-1) (from Ch. 23, par. 6-1)

3 Sec. 6-1. Eligibility requirements. Financial aid in
4 meeting basic maintenance requirements shall be given under
5 this Article to or in behalf of persons who meet the
6 eligibility conditions of Sections 6-1.1 through 6-1.10. In
7 addition, each unit of local government subject to this Article
8 shall provide persons receiving financial aid in meeting basic
9 maintenance requirements with financial aid for either (a)
10 necessary treatment, care, and supplies required because of
11 illness or disability, or (b) acute medical treatment, care,
12 and supplies only. If a local governmental unit elects to
13 provide financial aid for acute medical treatment, care, and
14 supplies only, the general types of acute medical treatment,
15 care, and supplies for which financial aid is provided shall be
16 specified in the general assistance rules of the local
17 governmental unit, which rules shall provide that financial aid
18 is provided, at a minimum, for acute medical treatment, care,
19 or supplies necessitated by a medical condition for which prior
20 approval or authorization of medical treatment, care, or
21 supplies is not required by the general assistance rules of the
22 Illinois Department. Nothing in this Article shall be construed
23 to permit the granting of financial aid where the purpose of
24 such aid is to obtain an abortion, induced miscarriage or
25 induced premature birth unless, in the opinion of a physician,

1 such procedures are necessary for the preservation of the life
2 of the woman seeking such treatment, or except an induced
3 premature birth intended to produce a live viable child and
4 such procedure is necessary for the health of the mother or her
5 unborn child.

6 (Source: P.A. 100-538, eff. 1-1-18.)

7 Section 15. The Problem Pregnancy Health Services and Care
8 Act is amended by changing Section 4-100 as follows:

9 (410 ILCS 230/4-100) (from Ch. 111 1/2, par. 4604-100)

10 Sec. 4-100. The Department may make grants to nonprofit
11 agencies and organizations which do not use such grants to
12 refer or counsel for, or perform, abortions and which
13 coordinate and establish linkages among services that will
14 further the purposes of this Act and, where appropriate, will
15 provide, supplement, or improve the quality of such services.

16 (Source: P.A. 100-538, eff. 1-1-18.)

17 Section 20. The Illinois Abortion Law of 1975 is amended by
18 changing Section 1 as follows:

19 (720 ILCS 510/1) (from Ch. 38, par. 81-21)

20 Sec. 1. It is the intention of the General Assembly of the
21 State of Illinois to reasonably regulate abortion in
22 conformance with the ~~legal standards set forth in the decisions~~

1 of the United States Supreme Court of January 22, 1973. Without
2 in any way restricting the right of privacy of a woman or the
3 right of a woman to an abortion under those decisions, the
4 General Assembly of the State of Illinois do solemnly declare
5 and find in reaffirmation of the longstanding policy of this
6 State, that the unborn child is a human being from the time of
7 conception and is, therefore, a legal person for purposes of
8 the unborn child's right to life and is entitled to the right
9 to life from conception under the laws and Constitution of this
10 State. Further, the General Assembly finds and declares that
11 longstanding policy of this State to protect the right to life
12 of the unborn child from conception by prohibiting abortion
13 unless necessary to preserve the life of the mother is
14 impermissible only because of the decisions of the United
15 States Supreme Court and that, therefore, if those decisions of
16 the United States Supreme Court are ever reversed or modified
17 or the United States Constitution is amended to allow
18 protection of the unborn then the former policy of this State
19 to prohibit abortions unless necessary for the preservation of
20 the mother's life shall be reinstated.

21 It is the further intention of the General Assembly to
22 assure and protect the woman's health and the integrity of the
23 woman's decision whether or not to continue to bear a child, to
24 protect the valid and compelling state interest in the infant
25 and unborn child, to assure the integrity of marital and
26 familial relations and the rights and interests of persons who

1 participate in such relations, and to gather data for
2 establishing criteria for medical decisions. The General
3 Assembly finds as fact, upon hearings and public disclosures,
4 that these rights and interests are not secure in the economic
5 and social context in which abortion is presently performed.

6 (Source: P.A. 100-538, eff. 1-1-18.)