

1 AN ACT concerning regulation.

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

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

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

7 Sec. 356g. Mammograms; mastectomies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 part of the breast for medically necessary reasons, as  
2 determined by a licensed physician.

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

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

20 (Source: P.A. 94-121, eff. 7-6-05; 95-431, eff. 8-24-07;  
21 95-1045, eff. 3-27-09.)

22 Section 10. The Illinois Public Aid Code is amended by  
23 changing Sections 5-5 and 5-16.8 and by adding Section 12-4.49  
24 as follows:

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

18 All screenings shall include a physical breast exam,  
19 instruction on self-examination and information regarding the  
20 frequency of self-examination and its value as a preventative  
21 tool. For purposes of this Section, "low-dose mammography"  
22 means the x-ray examination of the breast using equipment  
23 dedicated specifically for mammography, including the x-ray  
24 tube, filter, compression device, and image receptor, with an  
25 average radiation exposure delivery of less than one rad per  
26 breast for 2 views of an average size breast. The term also

1 includes digital mammography.

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

6 On and after January 1, 2012, providers participating in a  
7 quality improvement program approved by the Department shall be  
8 reimbursed for screening and diagnostic mammography at the same  
9 rate as the Medicare program's rates, including the increased  
10 reimbursement for digital mammography.

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

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

21 The Department shall convene an expert panel, including  
22 representatives of hospitals, free standing breast cancer  
23 treatment centers, breast cancer quality organizations, and  
24 doctors, including breast surgeons, reconstructive breast  
25 surgeons, oncologists, and primary care providers to establish  
26 quality standards for breast cancer treatment.

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

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

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

23           The Department shall devise a means of case-managing or  
24 patient navigation for beneficiaries diagnosed with breast  
25 cancer. This program shall initially operate as a pilot program  
26 in areas of the State with the highest incidence of mortality

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

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

19 Any medical or health care provider shall immediately  
20 recommend, to any pregnant woman who is being provided prenatal  
21 services and is suspected of drug abuse or is addicted as  
22 defined in the Alcoholism and Other Drug Abuse and Dependency  
23 Act, referral to a local substance abuse treatment provider  
24 licensed by the Department of Human Services or to a licensed  
25 hospital which provides substance abuse treatment services.  
26 The Department of Healthcare and Family Services shall assure

1 coverage for the cost of treatment of the drug abuse or  
2 addiction for pregnant recipients in accordance with the  
3 Illinois Medicaid Program in conjunction with the Department of  
4 Human Services.

5 All medical providers providing medical assistance to  
6 pregnant women under this Code shall receive information from  
7 the Department on the availability of services under the Drug  
8 Free Families with a Future or any comparable program providing  
9 case management services for addicted women, including  
10 information on appropriate referrals for other social services  
11 that may be needed by addicted women in addition to treatment  
12 for addiction.

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

21 Neither the Department of Healthcare and Family Services  
22 nor the Department of Human Services shall sanction the  
23 recipient solely on the basis of her substance abuse.

24 The Illinois Department shall establish such regulations  
25 governing the dispensing of health services under this Article  
26 as it shall deem appropriate. The Department should seek the

1 advice of formal professional advisory committees appointed by  
2 the Director of the Illinois Department for the purpose of  
3 providing regular advice on policy and administrative matters,  
4 information dissemination and educational activities for  
5 medical and health care providers, and consistency in  
6 procedures to the Illinois Department.

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

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

26 (1) Physicians participating in a Partnership and

1 providing certain services, which shall be determined by  
2 the Illinois Department, to persons in areas covered by the  
3 Partnership may receive an additional surcharge for such  
4 services.

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

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

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

21 Nothing in this Section shall limit the free choice of  
22 practitioners, hospitals, and other providers of medical  
23 services by clients. In order to ensure patient freedom of  
24 choice, the Illinois Department shall immediately promulgate  
25 all rules and take all other necessary actions so that provided  
26 services may be accessed from therapeutically certified



1 optometrists to the full extent of the Illinois Optometric  
2 Practice Act of 1987 without discriminating between service  
3 providers.

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

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

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

20 The rules and regulations of the Illinois Department shall  
21 require that a written statement including the required opinion  
22 of a physician shall accompany any claim for reimbursement for  
23 abortions, or induced miscarriages or premature births. This  
24 statement shall indicate what procedures were used in providing  
25 such medical services.

26 Notwithstanding any other law to the contrary, the Illinois

1 Department shall, within 365 days after July 22, 2013~~7~~ (the  
2 effective date of Public Act 98-104), establish procedures to  
3 permit skilled care facilities licensed under the Nursing Home  
4 Care Act to submit monthly billing claims for reimbursement  
5 purposes. Following development of these procedures, the  
6 Department shall have an additional 365 days to test the  
7 viability of the new system and to ensure that any necessary  
8 operational or structural changes to its information  
9 technology platforms are implemented.

10 Notwithstanding any other law to the contrary, the Illinois  
11 Department shall, within 365 days after the effective date of  
12 this amendatory Act of the 98th General Assembly, establish  
13 procedures to permit ID/DD facilities licensed under the ID/DD  
14 Community Care Act to submit monthly billing claims for  
15 reimbursement purposes. Following development of these  
16 procedures, the Department shall have an additional 365 days to  
17 test the viability of the new system and to ensure that any  
18 necessary operational or structural changes to its information  
19 technology platforms are implemented.

20 The Illinois Department shall require all dispensers of  
21 medical services, other than an individual practitioner or  
22 group of practitioners, desiring to participate in the Medical  
23 Assistance program established under this Article to disclose  
24 all financial, beneficial, ownership, equity, surety or other  
25 interests in any and all firms, corporations, partnerships,  
26 associations, business enterprises, joint ventures, agencies,

1 institutions or other legal entities providing any form of  
2 health care services in this State under this Article.

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

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

20 The Department has the discretion to limit the conditional  
21 enrollment period for vendors based upon category of risk of  
22 the vendor.

23 Prior to enrollment and during the conditional enrollment  
24 period in the medical assistance program, all vendors shall be  
25 subject to enhanced oversight, screening, and review based on  
26 the risk of fraud, waste, and abuse that is posed by the

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

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

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

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

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

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

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

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

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

23 In the case of long term care facilities, within 5 days of  
24 receipt by the facility of required prescreening information,  
25 data for new admissions shall be entered into the Medical  
26 Electronic Data Interchange (MEDI) or the Recipient

1 Eligibility Verification (REV) System or successor system, and  
2 within 15 days of receipt by the facility of required  
3 prescreening information, admission documents shall be  
4 submitted through MEDI or REV or shall be submitted directly to  
5 the Department of Human Services using required admission  
6 forms. Effective September 1, 2014, admission documents,  
7 including all prescreening information, must be submitted  
8 through MEDI or REV. Confirmation numbers assigned to an  
9 accepted transaction shall be retained by a facility to verify  
10 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;

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



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.

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 (Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689,  
10 eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section  
11 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff.  
12 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651,  
13 eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14;  
14 revised 10-2-14.)

15 (305 ILCS 5/5-16.8)

16 Sec. 5-16.8. Required health benefits. The medical  
17 assistance program shall (i) provide the post-mastectomy care  
18 benefits required to be covered by a policy of accident and  
19 health insurance under Section 356t and the coverage required  
20 under Sections 356g.5, 356u, 356w, 356x, and 356z.6 of the  
21 Illinois Insurance Code and (ii) be subject to the provisions  
22 of Sections 356z.19 and 364.01 of the Illinois Insurance Code.

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

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

3 To ensure full access to the benefits set forth in this  
4 Section, on and after January 1, 2016, the Department shall  
5 ensure that provider and hospital reimbursement for  
6 post-mastectomy care benefits required under this Section are  
7 no lower than the Medicare reimbursement rate.

8 (Source: P.A. 97-282, eff. 8-9-11; 97-689, eff. 6-14-12.)

9 (305 ILCS 5/12-4.49 new)

10 Sec. 12-4.49. Breast cancer imaging and diagnostic  
11 equipment grant program.

12 (a) On and after January 1, 2016 and subject to funding  
13 availability, the Department of Healthcare and Family Services  
14 shall administer a grant program the purpose of which shall be  
15 to build the public infrastructure for breast cancer imaging  
16 and diagnostic services across the State, in particular in  
17 rural, medically underserved areas and in areas with high  
18 breast cancer mortality.

19 (b) In order to be eligible for the program, an applicant  
20 must be a:

21 (1) disproportionate share hospital with high MIUR (as  
22 set by the Department by rule);

23 (2) mammography facility in a rural area;

24 (3) federally qualified health center; or

25 (4) rural health clinic.

1       (c) The grants may be used to purchase new equipment for  
2 breast imaging, image-guided biopsies, or other equipment to  
3 enhance the detection and diagnosis of breast cancer.

4       (d) The primary purpose of these grants is to increase  
5 access for low-income and Department of Healthcare and Family  
6 Services clients to high quality breast cancer screening and  
7 diagnostics. Medically Underserved Areas (MUAs), areas with  
8 high breast cancer mortality rates, and Health Professional  
9 Shortage Areas (HPSAs) shall receive special priority for  
10 grants under this program.

11       (e) The Department shall establish procedures for applying  
12 for grant funds under this Section.

13       Section 99. Effective date. This Act takes effect upon  
14 becoming law.