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.

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

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

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

(a-10) When health care services are available through contracted providers and a person does not comply with plan provisions specific to the use of contracted providers, the requirements of subsection (a-5) are not applicable. When a person does not comply with plan provisions specific to the use of contracted providers, plan provisions specific to the use of

1 non-contracted providers must be applied without distinction
2 for coverage required by this Section and shall be at least as
3 favorable as for other radiological examinations covered by the
4 policy or contract.

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

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

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

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

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

1 surgery to within 2 years after the date of the mastectomy. As
2 used in this Section, "mastectomy" means the removal of all or
3 part of the breast for medically necessary reasons, as
4 determined by a licensed physician.

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

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

22 (Source: P.A. 94-121, eff. 7-6-05; 95-431, eff. 8-24-07;
23 95-1045, eff. 3-27-09.)

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

1 (215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)
2 Sec. 4-6.1. Mammograms; mastectomies.
3 (a) Every contract or evidence of coverage issued by a
4 Health Maintenance Organization for persons who are residents
5 of this State shall contain coverage for screening by low-dose
6 mammography for all women 35 years of age or older for the
7 presence of occult breast cancer. The coverage shall be as
8 follows:
9 (1) A baseline mammogram for women 35 to 39 years of
10 age.
11 (2) An annual mammogram for women 40 years of age or
12 older.
13 (3) A mammogram at the age and intervals considered
14 medically necessary by the woman's health care provider for
15 women under 40 years of age and having a family history of
16 breast cancer, prior personal history of breast cancer,
17 positive genetic testing, or other risk factors.
18 (4) A comprehensive ultrasound screening of an entire
19 breast or breasts if a mammogram demonstrates
20 heterogeneous or dense breast tissue, when medically
21 necessary as determined by a physician licensed to practice
22 medicine in all of its branches.
23 For purposes of this Section, "low-dose mammography" means
24 the x-ray examination of the breast using equipment dedicated
25 specifically for mammography, including the x-ray tube,

1 filter, compression device, and image receptor, with radiation
2 exposure delivery of less than 1 rad per breast for 2 views of
3 an average size breast. The term also includes digital
4 mammography and may include breast tomosynthesis. As used in
5 this Section, the term "breast tomosynthesis" means a
6 radiologic procedure that involves the acquisition of
7 projection images over the stationary breast to produce
8 cross-sectional digital three-dimensional images of the
9 breast.
10 (a-5) Coverage as described in subsection (a) shall be
11 provided at no cost to the enrollee and shall not be applied to
12 an annual or lifetime maximum benefit.
13 (b) No contract or evidence of coverage issued by a health
14 maintenance organization that provides for the surgical
15 procedure known as a mastectomy shall be issued, amended,
16 delivered, or renewed in this State on or after the effective
17 date of this amendatory Act of the 92nd General Assembly unless
18 that coverage also provides for prosthetic devices or
19 reconstructive surgery incident to the mastectomy, providing
20 that the mastectomy is performed after the effective date of
21 this amendatory Act. Coverage for breast reconstruction in
22 connection with a mastectomy shall include:
23 (1) reconstruction of the breast upon which the
24 mastectomy has been performed;
25 (2) surgery and reconstruction of the other breast to
26 produce a symmetrical appearance; and

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

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

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

1 (c) Rulemaking authority to implement this amendatory Act
2 of the 95th General Assembly, if any, is conditioned on the
3 rules being adopted in accordance with all provisions of the
4 Illinois Administrative Procedure Act and all rules and
5 procedures of the Joint Committee on Administrative Rules; any
6 purported rule not so adopted, for whatever reason, is
7 unauthorized.
8 (Source: P.A. 94-121, eff. 7-6-05; 95-431, eff. 8-24-07;
9 95-1045, eff. 3-27-09.)

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

12 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
13 Sec. 5-5. Medical services. The Illinois Department, by
14 rule, shall determine the quantity and quality of and the rate
15 of reimbursement for the medical assistance for which payment
16 will be authorized, and the medical services to be provided,
17 which may include all or part of the following: (1) inpatient
18 hospital services; (2) outpatient hospital services; (3) other
19 laboratory and X-ray services; (4) skilled nursing home
20 services; (5) physicians' services whether furnished in the
21 office, the patient's home, a hospital, a skilled nursing home,
22 or elsewhere; (6) medical care, or any other type of remedial
23 care furnished by licensed practitioners; (7) home health care
24 services; (8) private duty nursing service; (9) clinic

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

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

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

Article.

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

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

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

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

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

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

The Illinois Department, by rule, may distinguish and classify the medical services to be provided only in accordance

1 with the classes of persons designated in Section 5-2.
2 The Department of Healthcare and Family Services must
3 provide coverage and reimbursement for amino acid-based
4 elemental formulas, regardless of delivery method, for the
5 diagnosis and treatment of (i) eosinophilic disorders and (ii)
6 short bowel syndrome when the prescribing physician has issued
7 a written order stating that the amino acid-based elemental
8 formula is medically necessary.
9 The Illinois Department shall authorize the provision of,
10 and shall authorize payment for, screening by low-dose
11 mammography for the presence of occult breast cancer for women
12 35 years of age or older who are eligible for medical
13 assistance under this Article, as follows:
14 (A) A baseline mammogram for women 35 to 39 years of
15 age.
16 (B) An annual mammogram for women 40 years of age or
17 older.
18 (C) A mammogram at the age and intervals considered
19 medically necessary by the woman's health care provider for
20 women under 40 years of age and having a family history of
21 breast cancer, prior personal history of breast cancer,
22 positive genetic testing, or other risk factors.
23 (D) A comprehensive ultrasound screening of an entire
24 breast or breasts if a mammogram demonstrates
25 heterogeneous or dense breast tissue, when medically
26 necessary as determined by a physician licensed to practice

1 medicine in all of its branches.

2 All screenings shall include a physical breast exam,
3 instruction on self-examination and information regarding the
4 frequency of self-examination and its value as a preventative
5 tool. For purposes of this Section, "low-dose mammography"
6 means the x-ray examination of the breast using equipment
7 dedicated specifically for mammography, including the x-ray
8 tube, filter, compression device, and image receptor, with an
9 average radiation exposure delivery of less than one rad per
10 breast for 2 views of an average size breast. The term also
11 includes digital mammography and may include breast
12 tomosynthesis. As used in this Section, the term "breast
13 tomosynthesis" means a radiologic procedure that involves the
14 acquisition of projection images over the stationary breast to
15 produce cross-sectional digital three-dimensional images of
16 the breast.

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

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

26 Subject to federal approval, the Department shall

1 establish a rate methodology for mammography at federally
2 qualified health centers and other encounter-rate clinics.
3 These clinics or centers may also collaborate with other
4 hospital-based mammography facilities.
5 The Department shall establish a methodology to remind
6 women who are age-appropriate for screening mammography, but
7 who have not received a mammogram within the previous 18
8 months, of the importance and benefit of screening mammography.
9 The Department shall establish a performance goal for
10 primary care providers with respect to their female patients
11 over age 40 receiving an annual mammogram. This performance
12 goal shall be used to provide additional reimbursement in the
13 form of a quality performance bonus to primary care providers
14 who meet that goal.
15 The Department shall devise a means of case-managing or
16 patient navigation for beneficiaries diagnosed with breast
17 cancer. This program shall initially operate as a pilot program
18 in areas of the State with the highest incidence of mortality
19 related to breast cancer. At least one pilot program site shall
20 be in the metropolitan Chicago area and at least one site shall
21 be outside the metropolitan Chicago area. An evaluation of the
22 pilot program shall be carried out measuring health outcomes
23 and cost of care for those served by the pilot program compared
24 to similarly situated patients who are not served by the pilot
25 program.
26 Any medical or health care provider shall immediately

1 recommend, to any pregnant woman who is being provided prenatal
2 services and is suspected of drug abuse or is addicted as
3 defined in the Alcoholism and Other Drug Abuse and Dependency
4 Act, referral to a local substance abuse treatment provider
5 licensed by the Department of Human Services or to a licensed
6 hospital which provides substance abuse treatment services.
7 The Department of Healthcare and Family Services shall assure
8 coverage for the cost of treatment of the drug abuse or
9 addiction for pregnant recipients in accordance with the
10 Illinois Medicaid Program in conjunction with the Department of
11 Human Services.
12 All medical providers providing medical assistance to
13 pregnant women under this Code shall receive information from
14 the Department on the availability of services under the Drug
15 Free Families with a Future or any comparable program providing
16 case management services for addicted women, including
17 information on appropriate referrals for other social services
18 that may be needed by addicted women in addition to treatment
19 for addiction.
20 The Illinois Department, in cooperation with the
21 Departments of Human Services (as successor to the Department
22 of Alcoholism and Substance Abuse) and Public Health, through a
23 public awareness campaign, may provide information concerning
24 treatment for alcoholism and drug abuse and addiction, prenatal
25 health care, and other pertinent programs directed at reducing
26 the number of drug-affected infants born to recipients of

1 medical assistance.
2 Neither the Department of Healthcare and Family Services
3 nor the Department of Human Services shall sanction the
4 recipient solely on the basis of her substance abuse.
5 The Illinois Department shall establish such regulations
6 governing the dispensing of health services under this Article
7 as it shall deem appropriate. The Department should seek the
8 advice of formal professional advisory committees appointed by
9 the Director of the Illinois Department for the purpose of
10 providing regular advice on policy and administrative matters,
11 information dissemination and educational activities for
12 medical and health care providers, and consistency in
13 procedures to the Illinois Department.
14 The Illinois Department may develop and contract with
15 Partnerships of medical providers to arrange medical services
16 for persons eligible under Section 5-2 of this Code.
17 Implementation of this Section may be by demonstration projects
18 in certain geographic areas. The Partnership shall be
19 represented by a sponsor organization. The Department, by rule,
20 shall develop qualifications for sponsors of Partnerships.
21 Nothing in this Section shall be construed to require that the
22 sponsor organization be a medical organization.
23 The sponsor must negotiate formal written contracts with
24 medical providers for physician services, inpatient and
25 outpatient hospital care, home health services, treatment for
26 alcoholism and substance abuse, and other services determined

1 necessary by the Illinois Department by rule for delivery by
2 Partnerships. Physician services must include prenatal and
3 obstetrical care. The Illinois Department shall reimburse
4 medical services delivered by Partnership providers to clients
5 in target areas according to provisions of this Article and the
6 Illinois Health Finance Reform Act, except that:
7 (1) Physicians participating in a Partnership and
8 providing certain services, which shall be determined by
9 the Illinois Department, to persons in areas covered by the
10 Partnership may receive an additional surcharge for such
11 services.
12 (2) The Department may elect to consider and negotiate
13 financial incentives to encourage the development of
14 Partnerships and the efficient delivery of medical care.
15 (3) Persons receiving medical services through
16 Partnerships may receive medical and case management
17 services above the level usually offered through the
18 medical assistance program.
19 Medical providers shall be required to meet certain
20 qualifications to participate in Partnerships to ensure the
21 delivery of high quality medical services. These
22 qualifications shall be determined by rule of the Illinois
23 Department and may be higher than qualifications for
24 participation in the medical assistance program. Partnership
25 sponsors may prescribe reasonable additional qualifications
26 for participation by medical providers, only with the prior

1 written approval of the Illinois Department.
2 Nothing in this Section shall limit the free choice of
3 practitioners, hospitals, and other providers of medical
4 services by clients. In order to ensure patient freedom of
5 choice, the Illinois Department shall immediately promulgate
6 all rules and take all other necessary actions so that provided
7 services may be accessed from therapeutically certified
8 optometrists to the full extent of the Illinois Optometric
9 Practice Act of 1987 without discriminating between service
10 providers.
11 The Department shall apply for a waiver from the United
12 States Health Care Financing Administration to allow for the
13 implementation of Partnerships under this Section.
14 The Illinois Department shall require health care
15 providers to maintain records that document the medical care
16 and services provided to recipients of Medical Assistance under
17 this Article. Such records must be retained for a period of not
18 less than 6 years from the date of service or as provided by
19 applicable State law, whichever period is longer, except that
20 if an audit is initiated within the required retention period
21 then the records must be retained until the audit is completed
22 and every exception is resolved. The Illinois Department shall
23 require health care providers to make available, when
24 authorized by the patient, in writing, the medical records in a
25 timely fashion to other health care providers who are treating
26 or serving persons eligible for Medical Assistance under this

1 Article. All dispensers of medical services shall be required
2 to maintain and retain business and professional records
3 sufficient to fully and accurately document the nature, scope,
4 details and receipt of the health care provided to persons
5 eligible for medical assistance under this Code, in accordance
6 with regulations promulgated by the Illinois Department. The
7 rules and regulations shall require that proof of the receipt
8 of prescription drugs, dentures, prosthetic devices and
9 eyeglasses by eligible persons under this Section accompany
10 each claim for reimbursement submitted by the dispenser of such
11 medical services. No such claims for reimbursement shall be
12 approved for payment by the Illinois Department without such
13 proof of receipt, unless the Illinois Department shall have put
14 into effect and shall be operating a system of post-payment
15 audit and review which shall, on a sampling basis, be deemed
16 adequate by the Illinois Department to assure that such drugs,
17 dentures, prosthetic devices and eyeglasses for which payment
18 is being made are actually being received by eligible
19 recipients. Within 90 days after the effective date of this
20 amendatory Act of 1984, the Illinois Department shall establish
21 a current list of acquisition costs for all prosthetic devices
22 and any other items recognized as medical equipment and
23 supplies reimbursable under this Article and shall update such
24 list on a quarterly basis, except that the acquisition costs of
25 all prescription drugs shall be updated no less frequently than
26 every 30 days as required by Section 5-5.12.

1 The rules and regulations of the Illinois Department shall
2 require that a written statement including the required opinion
3 of a physician shall accompany any claim for reimbursement for
4 abortions, or induced miscarriages or premature births. This
5 statement shall indicate what procedures were used in providing
6 such medical services.

7 Notwithstanding any other law to the contrary, the Illinois
8 Department shall, within 365 days after July 22, 2013~~,~~ (the
9 effective date of Public Act 98-104), establish procedures to
10 permit skilled care facilities licensed under the Nursing Home
11 Care Act to submit monthly billing claims for reimbursement
12 purposes. Following development of these procedures, the
13 Department shall have an additional 365 days to test the
14 viability of the new system and to ensure that any necessary
15 operational or structural changes to its information
16 technology platforms are implemented.

17 Notwithstanding any other law to the contrary, the Illinois
18 Department shall, within 365 days after August 15, 2014 (the
19 effective date of Public Act 98-963) ~~this amendatory Act of the~~
20 ~~98th General Assembly~~, establish procedures to permit ID/DD
21 facilities licensed under the ID/DD Community Care Act to
22 submit monthly billing claims for reimbursement purposes.
23 Following development of these procedures, the Department
24 shall have an additional 365 days to test the viability of the
25 new system and to ensure that any necessary operational or
26 structural changes to its information technology platforms are

1 implemented.
2 The Illinois Department shall require all dispensers of
3 medical services, other than an individual practitioner or
4 group of practitioners, desiring to participate in the Medical
5 Assistance program established under this Article to disclose
6 all financial, beneficial, ownership, equity, surety or other
7 interests in any and all firms, corporations, partnerships,
8 associations, business enterprises, joint ventures, agencies,
9 institutions or other legal entities providing any form of
10 health care services in this State under this Article.
11 The Illinois Department may require that all dispensers of
12 medical services desiring to participate in the medical
13 assistance program established under this Article disclose,
14 under such terms and conditions as the Illinois Department may
15 by rule establish, all inquiries from clients and attorneys
16 regarding medical bills paid by the Illinois Department, which
17 inquiries could indicate potential existence of claims or liens
18 for the Illinois Department.
19 Enrollment of a vendor shall be subject to a provisional
20 period and shall be conditional for one year. During the period
21 of conditional enrollment, the Department may terminate the
22 vendor's eligibility to participate in, or may disenroll the
23 vendor from, the medical assistance program without cause.
24 Unless otherwise specified, such termination of eligibility or
25 disenrollment is not subject to the Department's hearing
26 process. However, a disenrolled vendor may reapply without

penalty.

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

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

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

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

8 (1) In the case of a provider whose enrollment is in
9 process by the Illinois Department, the 180-day period
10 shall not begin until the date on the written notice from
11 the Illinois Department that the provider enrollment is
12 complete.

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

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

20 (4) In the case of a provider operated by a unit of
21 local government with a population exceeding 3,000,000
22 when local government funds finance federal participation
23 for claims payments.

24 For claims for services rendered during a period for which
25 a recipient received retroactive eligibility, claims must be
26 filed within 180 days after the Department determines the

applicant is eligible. For claims for which the Illinois Department is not the primary payer, claims must be submitted to the Illinois Department within 180 days after the final adjudication by the primary payer.

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

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

To the extent consistent with applicable information and

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

14 The Illinois Department shall enter into agreements with
15 State agencies and departments, and is authorized to enter into
16 agreements with federal agencies and departments, under which
17 such agencies and departments shall share data necessary for
18 medical assistance program integrity functions and oversight.
19 The Illinois Department shall develop, in cooperation with
20 other State departments and agencies, and in compliance with
21 applicable federal laws and regulations, appropriate and
22 effective methods to share such data. At a minimum, and to the
23 extent necessary to provide data sharing, the Illinois
24 Department shall enter into agreements with State agencies and
25 departments, and is authorized to enter into agreements with
26 federal agencies and departments, including but not limited to:

1 the Secretary of State; the Department of Revenue; the
2 Department of Public Health; the Department of Human Services;
3 and the Department of Financial and Professional Regulation.

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

18 The Illinois Department shall establish policies,
19 procedures, standards and criteria by rule for the acquisition,
20 repair and replacement of orthotic and prosthetic devices and
21 durable medical equipment. Such rules shall provide, but not be
22 limited to, the following services: (1) immediate repair or
23 replacement of such devices by recipients; and (2) rental,
24 lease, purchase or lease-purchase of durable medical equipment
25 in a cost-effective manner, taking into consideration the
26 recipient's medical prognosis, the extent of the recipient's

1 needs, and the requirements and costs for maintaining such
2 equipment. Subject to prior approval, such rules shall enable a
3 recipient to temporarily acquire and use alternative or
4 substitute devices or equipment pending repairs or
5 replacements of any device or equipment previously authorized
6 for such recipient by the Department.

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

1 providers access to eligibility scores for individuals with an
2 admission date who are seeking or receiving services from the
3 long term care provider. In order to select the minimum level
4 of care eligibility criteria, the Governor shall establish a
5 workgroup that includes affected agency representatives and
6 stakeholders representing the institutional and home and
7 community-based long term care interests. This Section shall
8 not restrict the Department from implementing lower level of
9 care eligibility criteria for community-based services in
10 circumstances where federal approval has been granted.

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

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

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

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

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

1 (d) efforts at utilization review and control by the
2 Illinois Department.
3 The period covered by each report shall be the 3 years
4 ending on the June 30 prior to the report. The report shall
5 include suggested legislation for consideration by the General
6 Assembly. The filing of one copy of the report with the
7 Speaker, one copy with the Minority Leader and one copy with
8 the Clerk of the House of Representatives, one copy with the
9 President, one copy with the Minority Leader and one copy with
10 the Secretary of the Senate, one copy with the Legislative
11 Research Unit, and such additional copies with the State
12 Government Report Distribution Center for the General Assembly
13 as is required under paragraph (t) of Section 7 of the State
14 Library Act shall be deemed sufficient to comply with this
15 Section.
16 Rulemaking authority to implement Public Act 95-1045, if
17 any, is conditioned on the rules being adopted in accordance
18 with all provisions of the Illinois Administrative Procedure
19 Act and all rules and procedures of the Joint Committee on
20 Administrative Rules; any purported rule not so adopted, for
21 whatever reason, is unauthorized.
22 On and after July 1, 2012, the Department shall reduce any
23 rate of reimbursement for services or other payments or alter
24 any methodologies authorized by this Code to reduce any rate of
25 reimbursement for services or other payments in accordance with
26 Section 5-5e.

1 Because kidney transplantation can be an appropriate, cost
2 effective alternative to renal dialysis when medically
3 necessary and notwithstanding the provisions of Section 1-11 of
4 this Code, beginning October 1, 2014, the Department shall
5 cover kidney transplantation for noncitizens with end-stage
6 renal disease who are not eligible for comprehensive medical
7 benefits, who meet the residency requirements of Section 5-3 of
8 this Code, and who would otherwise meet the financial
9 requirements of the appropriate class of eligible persons under
10 Section 5-2 of this Code. To qualify for coverage of kidney
11 transplantation, such person must be receiving emergency renal
12 dialysis services covered by the Department. Providers under
13 this Section shall be prior approved and certified by the
14 Department to perform kidney transplantation and the services
15 under this Section shall be limited to services associated with
16 kidney transplantation.
17 (Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689,
18 eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section
19 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff.
20 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651,
21 eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14;
22 revised 10-2-14.)

23 Section 99. Effective date. This Act takes effect upon
24 becoming law.