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Sen. John G. Mulroe

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1 AMENDMENT TO SENATE BILL 54

2 AMENDMENT NO. ______. Amend Senate Bill 54 by replacing
3 everything after the enacting clause with the following:

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.

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

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

(a-5) Coverage as described by subsection (a) shall be provided at no cost to the insured and shall not be applied to

1 an annual or lifetime maximum benefit.
2 (a-10) When health care services are available through
3 contracted providers and a person does not comply with plan
4 provisions specific to the use of contracted providers, the
5 requirements of subsection (a-5) are not applicable. When a
6 person does not comply with plan provisions specific to the use
7 of contracted providers, plan provisions specific to the use of
8 non-contracted providers must be applied without distinction
9 for coverage required by this Section and shall be at least as
10 favorable as for other radiological examinations covered by the
11 policy or contract.
12 (b) No policy of accident or health insurance that provides
13 for the surgical procedure known as a mastectomy shall be
14 issued, amended, delivered, or renewed in this State unless
15 that coverage also provides for prosthetic devices or
16 reconstructive surgery incident to the mastectomy. Coverage
17 for breast reconstruction in connection with a mastectomy shall
18 include:
19 (1) reconstruction of the breast upon which the
20 mastectomy has been performed;
21 (2) surgery and reconstruction of the other breast to
22 produce a symmetrical appearance; and
23 (3) prostheses and treatment for physical
24 complications at all stages of mastectomy, including
25 lymphedemas.
26 Care shall be determined in consultation with the attending

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

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

(c) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any

1 purported rule not so adopted, for whatever reason, is
2 unauthorized.
3 (Source: P.A. 94-121, eff. 7-6-05; 95-431, eff. 8-24-07;
4 95-1045, eff. 3-27-09.)

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

7 (215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)
8 Sec. 4-6.1. Mammograms; mastectomies.
9 (a) Every contract or evidence of coverage issued by a
10 Health Maintenance Organization for persons who are residents
11 of this State shall contain coverage for screening by low-dose
12 mammography for all women 35 years of age or older for the
13 presence of occult breast cancer. The coverage shall be as
14 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.
24 (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 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.

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

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

1 that the mastectomy is performed after the effective date of
2 this amendatory Act. Coverage for breast reconstruction in
3 connection with a mastectomy shall include:
4 (1) reconstruction of the breast upon which the
5 mastectomy has been performed;
6 (2) surgery and reconstruction of the other breast to
7 produce a symmetrical appearance; and
8 (3) prostheses and treatment for physical
9 complications at all stages of mastectomy, including
10 lymphedemas.
11 Care shall be determined in consultation with the attending
12 physician and the patient. The offered coverage for prosthetic
13 devices and reconstructive surgery shall be subject to the
14 deductible and coinsurance conditions applied to the
15 mastectomy and all other terms and conditions applicable to
16 other benefits. When a mastectomy is performed and there is no
17 evidence of malignancy, then the offered coverage may be
18 limited to the provision of prosthetic devices and
19 reconstructive surgery to within 2 years after the date of the
20 mastectomy. As used in this Section, "mastectomy" means the
21 removal of all or part of the breast for medically necessary
22 reasons, as determined by a licensed physician.
23 Written notice of the availability of coverage under this
24 Section shall be delivered to the enrollee upon enrollment and
25 annually thereafter. A health maintenance organization may not
26 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.

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

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

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

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient

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

1 includes an appropriate evaluation and, as warranted, a
2 referral; "uniform" does not mean the use of a singular
3 instrument, tool, or process that all must utilize; (14)
4 transportation and such other expenses as may be necessary;
5 (15) medical treatment of sexual assault survivors, as defined
6 in Section 1a of the Sexual Assault Survivors Emergency
7 Treatment Act, for injuries sustained as a result of the sexual
8 assault, including examinations and laboratory tests to
9 discover evidence which may be used in criminal proceedings
10 arising from the sexual assault; (16) the diagnosis and
11 treatment of sickle cell anemia; and (17) any other medical
12 care, and any other type of remedial care recognized under the
13 laws of this State, but not including abortions, or induced
14 miscarriages or premature births, unless, in the opinion of a
15 physician, such procedures are necessary for the preservation
16 of the life of the woman seeking such treatment, or except an
17 induced premature birth intended to produce a live viable child
18 and such procedure is necessary for the health of the mother or
19 her unborn child. The Illinois Department, by rule, shall
20 prohibit any physician from providing medical assistance to
21 anyone eligible therefor under this Code where such physician
22 has been found guilty of performing an abortion procedure in a
23 wilful and wanton manner upon a woman who was not pregnant at
24 the time such abortion procedure was performed. The term "any
25 other type of remedial care" shall include nursing care and
26 nursing home service for persons who rely on treatment by

1 spiritual means alone through prayer for healing.
2 Notwithstanding any other provision of this Section, a
3 comprehensive tobacco use cessation program that includes
4 purchasing prescription drugs or prescription medical devices
5 approved by the Food and Drug Administration shall be covered
6 under the medical assistance program under this Article for
7 persons who are otherwise eligible for assistance under this
8 Article.
9 Notwithstanding any other provision of this Code, the
10 Illinois Department may not require, as a condition of payment
11 for any laboratory test authorized under this Article, that a
12 physician's handwritten signature appear on the laboratory
13 test order form. The Illinois Department may, however, impose
14 other appropriate requirements regarding laboratory test order
15 documentation.
16 Upon receipt of federal approval of an amendment to the
17 Illinois Title XIX State Plan for this purpose, the Department
18 shall authorize the Chicago Public Schools (CPS) to procure a
19 vendor or vendors to manufacture eyeglasses for individuals
20 enrolled in a school within the CPS system. CPS shall ensure
21 that its vendor or vendors are enrolled as providers in the
22 medical assistance program and in any capitated Medicaid
23 managed care entity (MCE) serving individuals enrolled in a
24 school within the CPS system. Under any contract procured under
25 this provision, the vendor or vendors must serve only
26 individuals enrolled in a school within the CPS system. Claims

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

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

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

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

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

1 enrolled provider, as determined by the Department, through
2 which dental services covered under this Section are performed.
3 The Department shall establish a process for payment of claims
4 for reimbursement for covered dental services rendered under
5 this provision.

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

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

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

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

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

25 (C) A mammogram at the age and intervals considered
26 medically necessary by the woman's health care provider for

1 women under 40 years of age and having a family history of
2 breast cancer, prior personal history of breast cancer,
3 positive genetic testing, or other risk factors.

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

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

24 On and after January 1, 2012, providers participating in a
25 quality improvement program approved by the Department shall be
26 reimbursed for screening and diagnostic mammography at the same

1 rate as the Medicare program's rates, including the increased
2 reimbursement for digital mammography.
3 The Department shall convene an expert panel including
4 representatives of hospitals, free-standing mammography
5 facilities, and doctors, including radiologists, to establish
6 quality standards.
7 Subject to federal approval, the Department shall
8 establish a rate methodology for mammography at federally
9 qualified health centers and other encounter-rate clinics.
10 These clinics or centers may also collaborate with other
11 hospital-based mammography facilities.
12 The Department shall establish a methodology to remind
13 women who are age-appropriate for screening mammography, but
14 who have not received a mammogram within the previous 18
15 months, of the importance and benefit of screening mammography.
16 The Department shall establish a performance goal for
17 primary care providers with respect to their female patients
18 over age 40 receiving an annual mammogram. This performance
19 goal shall be used to provide additional reimbursement in the
20 form of a quality performance bonus to primary care providers
21 who meet that goal.
22 The Department shall devise a means of case-managing or
23 patient navigation for beneficiaries diagnosed with breast
24 cancer. This program shall initially operate as a pilot program
25 in areas of the State with the highest incidence of mortality
26 related to breast cancer. At least one pilot program site shall

be in the metropolitan Chicago area and at least one site shall be outside the metropolitan Chicago area. An evaluation of the pilot program shall be carried out measuring health outcomes and cost of care for those served by the pilot program compared to similarly situated patients who are not served by the pilot program.

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

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

1 The Illinois Department, in cooperation with the
2 Departments of Human Services (as successor to the Department
3 of Alcoholism and Substance Abuse) and Public Health, through a
4 public awareness campaign, may provide information concerning
5 treatment for alcoholism and drug abuse and addiction, prenatal
6 health care, and other pertinent programs directed at reducing
7 the number of drug-affected infants born to recipients of
8 medical assistance.

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

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

21 The Illinois Department may develop and contract with
22 Partnerships of medical providers to arrange medical services
23 for persons eligible under Section 5-2 of this Code.
24 Implementation of this Section may be by demonstration projects
25 in certain geographic areas. The Partnership shall be
26 represented by a sponsor organization. The Department, by rule,

shall develop qualifications for sponsors of Partnerships. Nothing in this Section shall be construed to require that the sponsor organization be a medical organization.

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

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

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

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

Medical providers shall be required to meet certain

1 qualifications to participate in Partnerships to ensure the
2 delivery of high quality medical services. These
3 qualifications shall be determined by rule of the Illinois
4 Department and may be higher than qualifications for
5 participation in the medical assistance program. Partnership
6 sponsors may prescribe reasonable additional qualifications
7 for participation by medical providers, only with the prior
8 written approval of the Illinois Department.

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

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

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

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

1 amendatory Act of 1984, the Illinois Department shall establish
2 a current list of acquisition costs for all prosthetic devices
3 and any other items recognized as medical equipment and
4 supplies reimbursable under this Article and shall update such
5 list on a quarterly basis, except that the acquisition costs of
6 all prescription drugs shall be updated no less frequently than
7 every 30 days as required by Section 5-5.12.

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

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

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

~~98th General Assembly~~, establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

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

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

Enrollment of a vendor shall be subject to a provisional

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

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

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

24 The Department shall define or specify the following: (i)
25 by provider notice, the "category of risk of the vendor" for
26 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.

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

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

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

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

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

For claims for services rendered during a period for which a recipient received retroactive eligibility, claims must be 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

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

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

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

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

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

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

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition,

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

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

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

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

25 The Illinois Department shall report annually to the
26 General Assembly, no later than the second Friday in April of

1 1979 and each year thereafter, in regard to:
2 (a) actual statistics and trends in utilization of
3 medical services by public aid recipients;
4 (b) actual statistics and trends in the provision of
5 the various medical services by medical vendors;
6 (c) current rate structures and proposed changes in
7 those rate structures for the various medical vendors; and
8 (d) efforts at utilization review and control by the
9 Illinois Department.
10 The period covered by each report shall be the 3 years
11 ending on the June 30 prior to the report. The report shall
12 include suggested legislation for consideration by the General
13 Assembly. The filing of one copy of the report with the
14 Speaker, one copy with the Minority Leader and one copy with
15 the Clerk of the House of Representatives, one copy with the
16 President, one copy with the Minority Leader and one copy with
17 the Secretary of the Senate, one copy with the Legislative
18 Research Unit, and such additional copies with the State
19 Government Report Distribution Center for the General Assembly
20 as is required under paragraph (t) of Section 7 of the State
21 Library Act shall be deemed sufficient to comply with this
22 Section.
23 Rulemaking authority to implement Public Act 95-1045, if
24 any, is conditioned on the rules being adopted in accordance
25 with all provisions of the Illinois Administrative Procedure
26 Act and all rules and procedures of the Joint Committee on

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

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

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

24 (Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689,
25 eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section
26 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff.

1 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; 98-651,
2 eff. 6-16-14; 98-756, eff. 7-16-14; 98-963, eff. 8-15-14;
3 revised 10-2-14.)

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