HB6285

98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

HB6285

by Rep. Mike Smiddy

SYNOPSIS AS INTRODUCED:

See Index

Amends the Illinois Insurance Code and the Illinois Public Aid Code. With regard to the respective requirements concerning coverage and payment for screening by low-dose mammography for all women 35 years of age or older for the presence of occult breast cancer, includes a screening MRI when medically necessary, as determined by a physician licensed to practice medicine in all of its branches, and if the American Cancer Society's guidelines for appropriate use for women at high risk for breast cancer are met. Further amends the Illinois Public Aid Code. Provides that on and after January 1, 2015, the Department of Healthcare and Family Services shall ensure that all networks of care for adult clients of the Department include access to at least one breast imaging Center of Imaging Excellence as certified by the American College of Radiology. Provides that on and after January 1, 2016, providers participating in a breast cancer treatment quality improvement program approved by the Department shall be reimbursed for breast cancer treatment at a rate that is no lower than 95% of the Medicare program's rates for the data elements included in the breast cancer treatment quality program. Makes changes concerning the case-managing and patient navigation pilot program. Sets forth provisions concerning departmental requirements for networks of care. Provides that on and after January 1, 2015, the Department shall ensure that provider and hospital reimbursement for certain required post-mastectomy care benefits are no lower than the Medicare reimbursement rate. Provides that on and after January 1, 2015 and subject to funding availability, the Department shall administer a grant program to build the public infrastructure for breast cancer imaging and diagnostic services across the State. Effective immediately.

LRB098 21659 RPM 60511 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

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, and if the American Cancer Society's
9 guidelines for appropriate use for women at high risk for
10 breast cancer are met.
11 For purposes of this Section, "low-dose mammography" means
12 the x-ray examination of the breast using equipment dedicated
13 specifically for mammography, including the x-ray tube,
14 filter, compression device, and image receptor, with radiation
15 exposure delivery of less than 1 rad per breast for 2 views of
16 an average size breast. The term also includes digital
17 mammography.
18 (a-5) Coverage as described by subsection (a) shall be
19 provided at no cost to the insured and shall not be applied to
20 an annual or lifetime maximum benefit.
21 (a-10) When health care services are available through
22 contracted providers and a person does not comply with plan
23 provisions specific to the use of contracted providers, the
24 requirements of subsection (a-5) are not applicable. When a
25 person does not comply with plan provisions specific to the use
26 of contracted providers, plan provisions specific to the use of

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

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

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

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

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

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

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 Illinois Public Aid Code is amended by
25 changing Sections 5-5 and 5-16.8 and by adding Section 12-4.47

1 as follows:

2 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)
3 Sec. 5-5. Medical services. The Illinois Department, by
4 rule, shall determine the quantity and quality of and the rate
5 of reimbursement for the medical assistance for which payment
6 will be authorized, and the medical services to be provided,
7 which may include all or part of the following: (1) inpatient
8 hospital services; (2) outpatient hospital services; (3) other
9 laboratory and X-ray services; (4) skilled nursing home
10 services; (5) physicians' services whether furnished in the
11 office, the patient's home, a hospital, a skilled nursing home,
12 or elsewhere; (6) medical care, or any other type of remedial
13 care furnished by licensed practitioners; (7) home health care
14 services; (8) private duty nursing service; (9) clinic
15 services; (10) dental services, including prevention and
16 treatment of periodontal disease and dental caries disease for
17 pregnant women, provided by an individual licensed to practice
18 dentistry or dental surgery; for purposes of this item (10),
19 "dental services" means diagnostic, preventive, or corrective
20 procedures provided by or under the supervision of a dentist in
21 the practice of his or her profession; (11) physical therapy
22 and related services; (12) prescribed drugs, dentures, and
23 prosthetic devices; and eyeglasses prescribed by a physician
24 skilled in the diseases of the eye, or by an optometrist,
25 whichever the person may select; (13) other diagnostic,

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

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

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

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

24 On and after July 1, 2012, the Department of Healthcare and
25 Family Services may provide the following services to persons
26 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 with the classes of persons designated in Section 5-2.

The Department of Healthcare and Family Services must provide coverage and reimbursement for amino acid-based

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

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

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

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

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

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

25 <u>(E) A screening MRI when medically necessary, as</u>
26 <u>determined by a physician licensed to practice medicine in</u>

1 all of its branches, and if the American Cancer Society's
2 guidelines for appropriate use for women at high risk for
3 breast cancer are met.
4 All screenings shall include a physical breast exam,
5 instruction on self-examination and information regarding the
6 frequency of self-examination and its value as a preventative
7 tool. For purposes of this Section, "low-dose mammography"
8 means the x-ray examination of the breast using equipment
9 dedicated specifically for mammography, including the x-ray
10 tube, filter, compression device, and image receptor, with an
11 average radiation exposure delivery of less than one rad per
12 breast for 2 views of an average size breast. The term also
13 includes digital mammography.
14 On and after January 1, 2015, the Department shall ensure
15 that all networks of care for adult clients of the Department
16 include access to at least one breast imaging Center of Imaging
17 Excellence as certified by the American College of Radiology.
18 On and after January 1, 2012, providers participating in a
19 quality improvement program approved by the Department shall be
20 reimbursed for screening and diagnostic mammography at the same
21 rate as the Medicare program's rates, including the increased
22 reimbursement for digital mammography.
23 The Department shall convene an expert panel including
24 representatives of hospitals, free-standing mammography
25 facilities, and doctors, including radiologists, to establish
26 quality standards for mammography.

1 On and after January 1, 2016, providers participating in a
2 breast cancer treatment quality improvement program approved
3 by the Department shall be reimbursed for breast cancer
4 treatment at a rate that is no lower than 95% of the Medicare
5 program's rates for the data elements included in the breast
6 cancer treatment quality program.

7 The Department shall convene an expert panel, including
8 representatives of hospitals, free standing breast cancer
9 treatment centers, breast cancer quality organizations, and
10 doctors, including breast surgeons, reconstructive breast
11 surgeons, oncologists, and primary care providers to establish
12 quality standards for breast cancer treatment.

13 Subject to federal approval, the Department shall
14 establish a rate methodology for mammography at federally
15 qualified health centers and other encounter-rate clinics.
16 These clinics or centers may also collaborate with other
17 hospital-based mammography facilities. By January 1, 2015, the
18 Department shall report to the General Assembly on the status
19 of the provision set forth in this paragraph.

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

effectiveness and modifying the methodology based on the evaluation.

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

The Department shall devise a means of case-managing or patient navigation for beneficiaries diagnosed with breast cancer. This program shall initially operate as a pilot program in areas of the State with the highest incidence of mortality 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. On or after July 1, 2015, the pilot program shall be expanded to include one site in western Illinois, one site in southern Illinois, one site in central Illinois, and 4 sites within metropolitan Chicago. 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.

The Department shall require all networks of care to develop a means either internally or by contract with experts in navigation and community outreach to navigate cancer patients to comprehensive care in a timely fashion. The

Department shall require all networks of care to include access for patients diagnosed with cancer to at least one academic commission on cancer-accredited cancer program as an in-network covered benefit.

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.

The Illinois Department, in cooperation with the Departments of Human Services (as successor to the Department

1 of Alcoholism and Substance Abuse) and Public Health, through a
2 public awareness campaign, may provide information concerning
3 treatment for alcoholism and drug abuse and addiction, prenatal
4 health care, and other pertinent programs directed at reducing
5 the number of drug-affected infants born to recipients of
6 medical assistance.

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

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

19 The Illinois Department may develop and contract with
20 Partnerships of medical providers to arrange medical services
21 for persons eligible under Section 5-2 of this Code.
22 Implementation of this Section may be by demonstration projects
23 in certain geographic areas. The Partnership shall be
24 represented by a sponsor organization. The Department, by rule,
25 shall develop qualifications for sponsors of Partnerships.
26 Nothing in this Section shall be construed to require that the

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 qualifications to participate in Partnerships to ensure the delivery of high quality medical services. These

1 qualifications shall be determined by rule of the Illinois
2 Department and may be higher than qualifications for
3 participation in the medical assistance program. Partnership
4 sponsors may prescribe reasonable additional qualifications
5 for participation by medical providers, only with the prior
6 written approval of the Illinois Department.

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

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

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

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

and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

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

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after July 22, 2013 (the effective date of Public Act 98-104) ~~this amendatory Act of the 98th General Assembly~~, establish procedures to permit skilled care facilities licensed under the Nursing Home 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

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

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

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

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

26 Prior to enrollment and during the conditional enrollment

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

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

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

1 medical goods or services were provided, with the following
2 exceptions:
3 (1) In the case of a provider whose enrollment is in
4 process by the Illinois Department, the 180-day period
5 shall not begin until the date on the written notice from
6 the Illinois Department that the provider enrollment is
7 complete.
8 (2) In the case of errors attributable to the Illinois
9 Department or any of its claims processing intermediaries
10 which result in an inability to receive, process, or
11 adjudicate a claim, the 180-day period shall not begin
12 until the provider has been notified of the error.
13 (3) In the case of a provider for whom the Illinois
14 Department initiates the monthly billing process.
15 (4) In the case of a provider operated by a unit of
16 local government with a population exceeding 3,000,000
17 when local government funds finance federal participation
18 for claims payments.
19 For claims for services rendered during a period for which
20 a recipient received retroactive eligibility, claims must be
21 filed within 180 days after the Department determines the
22 applicant is eligible. For claims for which the Illinois
23 Department is not the primary payer, claims must be submitted
24 to the Illinois Department within 180 days after the final
25 adjudication by the primary payer.
26 In the case of long term care facilities, admission

1 documents shall be submitted within 30 days of an admission to
2 the facility through the Medical Electronic Data Interchange
3 (MEDI) or the Recipient Eligibility Verification (REV) System,
4 or shall be submitted directly to the Department of Human
5 Services using required admission forms. Confirmation numbers
6 assigned to an accepted transaction shall be retained by a
7 facility to verify timely submittal. Once an admission
8 transaction has been completed, all resubmitted claims
9 following prior rejection are subject to receipt no later than
10 180 days after the admission transaction has been completed.

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

15 To the extent consistent with applicable information and
16 privacy, security, and disclosure laws, State and federal
17 agencies and departments shall provide the Illinois Department
18 access to confidential and other information and data necessary
19 to perform eligibility and payment verifications and other
20 Illinois Department functions. This includes, but is not
21 limited to: information pertaining to licensure;
22 certification; earnings; immigration status; citizenship; wage
23 reporting; unearned and earned income; pension income;
24 employment; supplemental security income; social security
25 numbers; National Provider Identifier (NPI) numbers; the
26 National Practitioner Data Bank (NPDB); program and agency

1 exclusions; taxpayer identification numbers; tax delinquency;
2 corporate information; and death records.
3 The Illinois Department shall enter into agreements with
4 State agencies and departments, and is authorized to enter into
5 agreements with federal agencies and departments, under which
6 such agencies and departments shall share data necessary for
7 medical assistance program integrity functions and oversight.
8 The Illinois Department shall develop, in cooperation with
9 other State departments and agencies, and in compliance with
10 applicable federal laws and regulations, appropriate and
11 effective methods to share such data. At a minimum, and to the
12 extent necessary to provide data sharing, the Illinois
13 Department shall enter into agreements with State agencies and
14 departments, and is authorized to enter into agreements with
15 federal agencies and departments, including but not limited to:
16 the Secretary of State; the Department of Revenue; the
17 Department of Public Health; the Department of Human Services;
18 and the Department of Financial and Professional Regulation.
19 Beginning in fiscal year 2013, the Illinois Department
20 shall set forth a request for information to identify the
21 benefits of a pre-payment, post-adjudication, and post-edit
22 claims system with the goals of streamlining claims processing
23 and provider reimbursement, reducing the number of pending or
24 rejected claims, and helping to ensure a more transparent
25 adjudication process through the utilization of: (i) provider
26 data verification and provider screening technology; and (ii)

1 clinical code editing; and (iii) pre-pay, pre- or
2 post-adjudicated predictive modeling with an integrated case
3 management system with link analysis. Such a request for
4 information shall not be considered as a request for proposal
5 or as an obligation on the part of the Illinois Department to
6 take any action or acquire any products or services.
7 The Illinois Department shall establish policies,
8 procedures, standards and criteria by rule for the acquisition,
9 repair and replacement of orthotic and prosthetic devices and
10 durable medical equipment. Such rules shall provide, but not be
11 limited to, the following services: (1) immediate repair or
12 replacement of such devices by recipients; and (2) rental,
13 lease, purchase or lease-purchase of durable medical equipment
14 in a cost-effective manner, taking into consideration the
15 recipient's medical prognosis, the extent of the recipient's
16 needs, and the requirements and costs for maintaining such
17 equipment. Subject to prior approval, such rules shall enable a
18 recipient to temporarily acquire and use alternative or
19 substitute devices or equipment pending repairs or
20 replacements of any device or equipment previously authorized
21 for such recipient by the Department.
22 The Department shall execute, relative to the nursing home
23 prescreening project, written inter-agency agreements with the
24 Department of Human Services and the Department on Aging, to
25 effect the following: (i) intake procedures and common
26 eligibility criteria for those persons who are receiving

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

1 cooperation with other State Departments and agencies and in
2 compliance with applicable federal laws and regulations,
3 appropriate and effective systems of health care evaluation and
4 programs for monitoring of utilization of health care services
5 and facilities, as it affects persons eligible for medical
6 assistance under this Code.

7 The Illinois Department shall report annually to the
8 General Assembly, no later than the second Friday in April of
9 1979 and each year thereafter, in regard to:

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

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

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

16 (d) efforts at utilization review and control by the
17 Illinois Department.

18 The period covered by each report shall be the 3 years
19 ending on the June 30 prior to the report. The report shall
20 include suggested legislation for consideration by the General
21 Assembly. The filing of one copy of the report with the
22 Speaker, one copy with the Minority Leader and one copy with
23 the Clerk of the House of Representatives, one copy with the
24 President, one copy with the Minority Leader and one copy with
25 the Secretary of the Senate, one copy with the Legislative
26 Research Unit, and such additional copies with the State

1 Government Report Distribution Center for the General Assembly
2 as is required under paragraph (t) of Section 7 of the State
3 Library Act shall be deemed sufficient to comply with this
4 Section.

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

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

16 (Source: P.A. 97-48, eff. 6-28-11; 97-638, eff. 1-1-12; 97-689,
17 eff. 6-14-12; 97-1061, eff. 8-24-12; 98-104, Article 9, Section
18 9-5, eff. 7-22-13; 98-104, Article 12, Section 12-20, eff.
19 7-22-13; 98-303, eff. 8-9-13; 98-463, eff. 8-16-13; revised
20 9-19-13.)

21 (305 ILCS 5/5-16.8)

22 Sec. 5-16.8. Required health benefits. The medical
23 assistance program shall (i) provide the post-mastectomy care
24 benefits required to be covered by a policy of accident and
25 health insurance under Section 356t and the coverage required

under Sections 356g.5, 356u, 356w, 356x, and 356z.6 of the Illinois Insurance Code and (ii) be subject to the provisions of Sections 356z.19 and 364.01 of the Illinois Insurance Code.

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

To ensure full access to the benefits set forth in this Section, on and after January 1, 2015, the Department shall ensure that provider and hospital reimbursement for post-mastectomy care benefits required under this Section are no lower than the Medicare reimbursement rate.

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

(305 ILCS 5/12-4.47 new)

Sec. 12-4.47. Breast cancer imaging and diagnostic equipment grant program.

(a) On and after January 1, 2015 and subject to funding availability, the Department of Healthcare and Family Services shall administer a grant program the purpose of which shall be to build the public infrastructure for breast cancer imaging and diagnostic services across the State, in particular in rural, medically underserved areas and in areas with high breast cancer mortality.

(b) In order to be eligible for the program, an applicant

1 must be a:
2 (1) disproportionate share hospital with high MIUR (as
3 set by the Department by rule);
4 (2) mammography facility in a rural area;
5 (3) federally qualified health center; or
6 (4) rural health clinic.
7 (c) The grants may be used to purchase new equipment for
8 breast imaging, image-guided biopsies, or other equipment to
9 enhance the detection and diagnosis of breast cancer.
10 (d) The primary purpose of these grants is to increase
11 access for low-income and Department of Healthcare and Family
12 Services clients to high quality breast cancer screening and
13 diagnostics. Medically Underserved Areas (MUAs), areas with
14 high breast cancer mortality rates, and Health Professional
15 Shortage Areas (HPSAs) shall receive special priority for
16 grants under this program.
17 (e) The Department shall establish procedures for applying
18 for grant funds under this Section.

19 Section 99. Effective date. This Act takes effect upon
20 becoming law.

1 INDEX

2 Statutes amended in order of appearance

3 215 ILCS 5/356g from Ch. 73, par. 968g
4 305 ILCS 5/5-5 from Ch. 23, par. 5-5
5 305 ILCS 5/5-16.8
6 305 ILCS 5/12-4.47 new