



## 103RD GENERAL ASSEMBLY

### State of Illinois

### 2023 and 2024

#### HB4180

Introduced 10/25/2023, by Rep. Nabeela Syed - Michael J. Kelly  
- Jeff Keicher

#### SYNOPSIS AS INTRODUCED:

55 ILCS 5/5-1069	from Ch. 34, par. 5-1069
65 ILCS 5/10-4-2	from Ch. 24, par. 10-4-2
215 ILCS 5/356g	from Ch. 73, par. 968g
215 ILCS 125/4-6.1	from Ch. 111 1/2, par. 1408.7
305 ILCS 5/5-5	from Ch. 23, par. 5-5

Amends the Counties Code, the Illinois Municipal Code, the Illinois Insurance Code, the Health Maintenance Organization Act, and the Illinois Public Aid Code. In provisions concerning coverage for mammograms, provides that coverage for certain types of mammography shall be made available to patients of a specified age (rather than only women of a specified age). Makes changes to require coverage for molecular breast imaging and, in those cases where its not already covered, magnetic resonance imaging of breast tissue. Provides that the Department of Healthcare and Family Services shall convene an expert panel, including representatives of hospitals, free-standing breast cancer treatment centers, breast cancer quality organizations, and doctors, including radiologists that are trained in all forms of FDA approved breast imaging technologies, breast surgeons, reconstructive breast, surgeons, oncologists, and primary care providers to establish quality standards for breast cancer treatment. Makes technical changes. Effective immediately.

LRB103 34255 MXP 64081 b

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 Counties Code is amended by changing  
5 Section 5-1069 as follows:

6 (55 ILCS 5/5-1069) (from Ch. 34, par. 5-1069)

7 Sec. 5-1069. Group life, health, accident, hospital, and  
8 medical insurance.

9 (a) The county board of any county may arrange to provide,  
10 for the benefit of employees of the county, group life,  
11 health, accident, hospital, and medical insurance, or any one  
12 or any combination of those types of insurance, or the county  
13 board may self-insure, for the benefit of its employees, all  
14 or a portion of the employees' group life, health, accident,  
15 hospital, and medical insurance, or any one or any combination  
16 of those types of insurance, including a combination of  
17 self-insurance and other types of insurance authorized by this  
18 Section, provided that the county board complies with all  
19 other requirements of this Section. The insurance may include  
20 provision for employees who rely on treatment by prayer or  
21 spiritual means alone for healing in accordance with the  
22 tenets and practice of a well recognized religious  
23 denomination. The county board may provide for payment by the

1 county of a portion or all of the premium or charge for the  
2 insurance with the employee paying the balance of the premium  
3 or charge, if any. If the county board undertakes a plan under  
4 which the county pays only a portion of the premium or charge,  
5 the county board shall provide for withholding and deducting  
6 from the compensation of those employees who consent to join  
7 the plan the balance of the premium or charge for the  
8 insurance.

9 (b) If the county board does not provide for  
10 self-insurance or for a plan under which the county pays a  
11 portion or all of the premium or charge for a group insurance  
12 plan, the county board may provide for withholding and  
13 deducting from the compensation of those employees who consent  
14 thereto the total premium or charge for any group life,  
15 health, accident, hospital, and medical insurance.

16 (c) The county board may exercise the powers granted in  
17 this Section only if it provides for self-insurance or, where  
18 it makes arrangements to provide group insurance through an  
19 insurance carrier, if the kinds of group insurance are  
20 obtained from an insurance company authorized to do business  
21 in the State of Illinois. The county board may enact an  
22 ordinance prescribing the method of operation of the insurance  
23 program.

24 (d) If a county, including a home rule county, is a  
25 self-insurer for purposes of providing health insurance  
26 coverage for its employees, the insurance coverage shall

1 include screening by low-dose mammography for all patients  
2 ~~women~~ 35 years of age or older for the presence of occult  
3 breast cancer unless the county elects to provide mammograms  
4 itself under Section 5-1069.1. The coverage shall be as  
5 follows:

6 (1) A baseline mammogram for patients ~~women~~ 35 to 39  
7 years of age.

8 (2) An annual mammogram for patients ~~women~~ 40 years of  
9 age or older.

10 (3) A mammogram at the age and intervals considered  
11 medically necessary by the patient's ~~woman's~~ health care  
12 provider for patients ~~women~~ under 40 years of age and  
13 having a family history of breast cancer, prior personal  
14 history of breast cancer, positive genetic testing, or  
15 other risk factors.

16 (4) For a group policy of accident and health  
17 insurance that is amended, delivered, issued, or renewed  
18 on or after January 1, 2020 (the effective date of Public  
19 Act 101-580) ~~this amendatory Act of the 101st General~~  
20 ~~Assembly~~, a comprehensive ultrasound screening of an  
21 entire breast or breasts if a mammogram demonstrates  
22 heterogeneous or dense breast tissue or when medically  
23 necessary as determined by a physician licensed to  
24 practice medicine in all of its branches, advanced  
25 practice registered nurse, or physician assistant.

26 (4.5) For a group policy of accident and health

1 insurance that is amended, delivered, issued, or renewed  
2 on or after the effective date of this amendatory Act of  
3 the 103rd General Assembly, molecular breast imaging (MBI)  
4 and magnetic resonance imaging of an entire breast or  
5 breasts if a mammogram demonstrates heterogeneous or dense  
6 breast tissue or when medically necessary as determined by  
7 a physician licensed to practice medicine in all of its  
8 branches.

9 (5) For a group policy of accident and health  
10 insurance that is amended, delivered, issued, or renewed  
11 on or after January 1, 2020 (the effective date of Public  
12 Act 101-580) ~~this amendatory Act of the 101st General~~  
13 ~~Assembly~~, a diagnostic mammogram when medically necessary,  
14 as determined by a physician licensed to practice medicine  
15 in all its branches, advanced practice registered nurse,  
16 or physician assistant.

17 A policy subject to this subsection shall not impose a  
18 deductible, coinsurance, copayment, or any other cost-sharing  
19 requirement on the coverage provided; except that this  
20 sentence does not apply to coverage of diagnostic mammograms  
21 to the extent such coverage would disqualify a high-deductible  
22 health plan from eligibility for a health savings account  
23 pursuant to Section 223 of the Internal Revenue Code (26  
24 U.S.C. 223).

25 For purposes of this subsection:

26 "Diagnostic mammogram" means a mammogram obtained using

1 diagnostic mammography.

2 "Diagnostic mammography" means a method of screening that  
3 is designed to evaluate an abnormality in a breast, including  
4 an abnormality seen or suspected on a screening mammogram or a  
5 subjective or objective abnormality otherwise detected in the  
6 breast.

7 "Low-dose mammography" means the x-ray examination of the  
8 breast using equipment dedicated specifically for mammography,  
9 including the x-ray tube, filter, compression device, and  
10 image receptor, with an average radiation exposure delivery of  
11 less than one rad per breast for 2 views of an average size  
12 breast. The term also includes digital mammography.

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

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

26 (d-15) If a county, including a home rule county, is a

1 self-insurer for purposes of providing health insurance  
2 coverage for its employees, the insurance coverage shall  
3 include mastectomy coverage, which includes coverage for  
4 prosthetic devices or reconstructive surgery incident to the  
5 mastectomy. Coverage for breast reconstruction in connection  
6 with a mastectomy shall include:

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

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

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

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

26 A county, including a home rule county, that is a

1 self-insurer for purposes of providing health insurance  
2 coverage for its employees, may not penalize or reduce or  
3 limit the reimbursement of an attending provider or provide  
4 incentives (monetary or otherwise) to an attending provider to  
5 induce the provider to provide care to an insured in a manner  
6 inconsistent with this Section.

7 (d-20) The requirement that mammograms be included in  
8 health insurance coverage as provided in subsections (d)  
9 through (d-15) is an exclusive power and function of the State  
10 and is a denial and limitation under Article VII, Section 6,  
11 subsection (h) of the Illinois Constitution of home rule  
12 county powers. A home rule county to which subsections (d)  
13 through (d-15) apply must comply with every provision of those  
14 subsections.

15 (e) The term "employees" as used in this Section includes  
16 elected or appointed officials but does not include temporary  
17 employees.

18 (f) The county board may, by ordinance, arrange to provide  
19 group life, health, accident, hospital, and medical insurance,  
20 or any one or a combination of those types of insurance, under  
21 this Section to retired former employees and retired former  
22 elected or appointed officials of the county.

23 (g) Rulemaking authority to implement this amendatory Act  
24 of the 95th General Assembly, if any, is conditioned on the  
25 rules being adopted in accordance with all provisions of the  
26 Illinois Administrative Procedure Act and all rules and



1 procedures of the Joint Committee on Administrative Rules; any  
2 purported rule not so adopted, for whatever reason, is  
3 unauthorized.

4 (Source: P.A. 100-513, eff. 1-1-18; 101-580, eff. 1-1-20.)

5 Section 10. The Illinois Municipal Code is amended by  
6 changing Section 10-4-2 as follows:

7 (65 ILCS 5/10-4-2) (from Ch. 24, par. 10-4-2)

8 Sec. 10-4-2. Group insurance.

9 (a) The corporate authorities of any municipality may  
10 arrange to provide, for the benefit of employees of the  
11 municipality, group life, health, accident, hospital, and  
12 medical insurance, or any one or any combination of those  
13 types of insurance, and may arrange to provide that insurance  
14 for the benefit of the spouses or dependents of those  
15 employees. The insurance may include provision for employees  
16 or other insured persons who rely on treatment by prayer or  
17 spiritual means alone for healing in accordance with the  
18 tenets and practice of a well recognized religious  
19 denomination. The corporate authorities may provide for  
20 payment by the municipality of a portion of the premium or  
21 charge for the insurance with the employee paying the balance  
22 of the premium or charge. If the corporate authorities  
23 undertake a plan under which the municipality pays a portion  
24 of the premium or charge, the corporate authorities shall

1 provide for withholding and deducting from the compensation of  
2 those municipal employees who consent to join the plan the  
3 balance of the premium or charge for the insurance.

4 (b) If the corporate authorities do not provide for a plan  
5 under which the municipality pays a portion of the premium or  
6 charge for a group insurance plan, the corporate authorities  
7 may provide for withholding and deducting from the  
8 compensation of those employees who consent thereto the  
9 premium or charge for any group life, health, accident,  
10 hospital, and medical insurance.

11 (c) The corporate authorities may exercise the powers  
12 granted in this Section only if the kinds of group insurance  
13 are obtained from an insurance company authorized to do  
14 business in the State of Illinois, or are obtained through an  
15 intergovernmental joint self-insurance pool as authorized  
16 under the Intergovernmental Cooperation Act. The corporate  
17 authorities may enact an ordinance prescribing the method of  
18 operation of the insurance program.

19 (d) If a municipality, including a home rule municipality,  
20 is a self-insurer for purposes of providing health insurance  
21 coverage for its employees, the insurance coverage shall  
22 include screening by low-dose mammography for all patients  
23 ~~women~~ 35 years of age or older for the presence of occult  
24 breast cancer unless the municipality elects to provide  
25 mammograms itself under Section 10-4-2.1. The coverage shall  
26 be as follows:

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

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

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

11 (4) For a group policy of accident and health  
12 insurance that is amended, delivered, issued, or renewed  
13 on or after January 1, 2020 (the effective date of Public  
14 Act 101-580) ~~this amendatory Act of the 101st General~~  
15 ~~Assembly,~~ a comprehensive ultrasound screening of an  
16 entire breast or breasts if a mammogram demonstrates  
17 heterogeneous or dense breast tissue or when medically  
18 necessary as determined by a physician licensed to  
19 practice medicine in all of its branches.

20 (4.5) For a group policy of accident and health  
21 insurance that is amended, delivered, issued, or renewed  
22 on or after the effective date of this amendatory Act of  
23 the 103rd General Assembly, molecular breast imaging (MBI)  
24 and magnetic resonance imaging of an entire breast or  
25 breasts if a mammogram demonstrates heterogeneous or dense  
26 breast tissue or when medically necessary as determined by

1       a physician licensed to practice medicine in all of its  
2       branches.

3           (5) For a group policy of accident and health  
4       insurance that is amended, delivered, issued, or renewed  
5       on or after January 1, 2020, (the effective date of Public  
6       Act 101-580) ~~this amendatory Act of the 101st General~~  
7       ~~Assembly,~~ a diagnostic mammogram when medically necessary,  
8       as determined by a physician licensed to practice medicine  
9       in all its branches, advanced practice registered nurse,  
10       or physician assistant.

11       A policy subject to this subsection shall not impose a  
12       deductible, coinsurance, copayment, or any other cost-sharing  
13       requirement on the coverage provided; except that this  
14       sentence does not apply to coverage of diagnostic mammograms  
15       to the extent such coverage would disqualify a high-deductible  
16       health plan from eligibility for a health savings account  
17       pursuant to Section 223 of the Internal Revenue Code (26  
18       U.S.C. 223).

19       For purposes of this subsection:

20       "Diagnostic mammogram" means a mammogram obtained using  
21       diagnostic mammography.

22       "Diagnostic mammography" means a method of screening that  
23       is designed to evaluate an abnormality in a breast, including  
24       an abnormality seen or suspected on a screening mammogram or a  
25       subjective or objective abnormality otherwise detected in the  
26       breast.

1 "Low-dose mammography" means the x-ray examination of the  
2 breast using equipment dedicated specifically for mammography,  
3 including the x-ray tube, filter, compression device, and  
4 image receptor, with an average radiation exposure delivery of  
5 less than one rad per breast for 2 views of an average size  
6 breast. The term also includes digital mammography.

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

10 (d-10) When health care services are available through  
11 contracted providers and a person does not comply with plan  
12 provisions specific to the use of contracted providers, the  
13 requirements of subsection (d-5) are not applicable. When a  
14 person does not comply with plan provisions specific to the  
15 use of contracted providers, plan provisions specific to the  
16 use of non-contracted providers must be applied without  
17 distinction for coverage required by this Section and shall be  
18 at least as favorable as for other radiological examinations  
19 covered by the policy or contract.

20 (d-15) If a municipality, including a home rule  
21 municipality, is a self-insurer for purposes of providing  
22 health insurance coverage for its employees, the insurance  
23 coverage shall include mastectomy coverage, which includes  
24 coverage for prosthetic devices or reconstructive surgery  
25 incident to the mastectomy. Coverage for breast reconstruction  
26 in connection with a mastectomy shall include:

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

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

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

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

20           A municipality, including a home rule municipality, that  
21 is a self-insurer for purposes of providing health insurance  
22 coverage for its employees, may not penalize or reduce or  
23 limit the reimbursement of an attending provider or provide  
24 incentives (monetary or otherwise) to an attending provider to  
25 induce the provider to provide care to an insured in a manner  
26 inconsistent with this Section.

1 (d-20) The requirement that mammograms be included in  
2 health insurance coverage as provided in subsections (d)  
3 through (d-15) is an exclusive power and function of the State  
4 and is a denial and limitation under Article VII, Section 6,  
5 subsection (h) of the Illinois Constitution of home rule  
6 municipality powers. A home rule municipality to which  
7 subsections (d) through (d-15) apply must comply with every  
8 provision of those subsections.

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

15 (Source: P.A. 100-863, eff. 8-14-18; 101-580, eff. 1-1-20.)

16 Section 15. The Illinois Insurance Code is amended by  
17 changing Section 356g as follows:

18 (215 ILCS 5/356g) (from Ch. 73, par. 968g)

19 Sec. 356g. Mammograms; mastectomies.

20 (a) Every insurer shall provide in each group or  
21 individual policy, contract, or certificate of insurance  
22 issued or renewed for persons who are residents of this State,  
23 coverage for screening by low-dose mammography for all  
24 patients ~~women~~ 35 years of age or older for the presence of

1 occult breast cancer within the provisions of the policy,  
2 contract, or certificate. The coverage shall be as follows:

3 (1) A baseline mammogram for patients ~~women~~ 35 to 39  
4 years of age.

5 (2) An annual mammogram for patients ~~women~~ 40 years  
6 of age or older.

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

13 (4) For an individual or group policy of accident and  
14 health insurance or a managed care plan that is amended,  
15 delivered, issued, or renewed on or after January 1, 2020  
16 (the effective date of Public Act 101-580) ~~this amendatory~~  
17 ~~Act of the 101st General Assembly~~, a comprehensive  
18 ultrasound screening and MRI of an entire breast or  
19 breasts if a mammogram demonstrates heterogeneous or dense  
20 breast tissue or when medically necessary as determined by  
21 a physician licensed to practice medicine in all of its  
22 branches.

23 (4.5) For a group policy of accident and health  
24 insurance that is amended, delivered, issued, or renewed  
25 on or after the effective date of this amendatory Act of  
26 the 103rd General Assembly, molecular breast imaging (MBI)



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

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

8           (6) For an individual or group policy of accident and  
9       health insurance or a managed care plan that is amended,  
10      delivered, issued, or renewed on or after January 1, 2020  
11      (the effective date of Public Act 101-580) ~~this amendatory~~  
12      ~~Act of the 101st General Assembly~~, a diagnostic mammogram  
13      when medically necessary, as determined by a physician  
14      licensed to practice medicine in all its branches,  
15      advanced practice registered nurse, or physician  
16      assistant.

17      A policy subject to this subsection shall not impose a  
18      deductible, coinsurance, copayment, or any other cost-sharing  
19      requirement on the coverage provided; except that this  
20      sentence does not apply to coverage of diagnostic mammograms  
21      to the extent such coverage would disqualify a high-deductible  
22      health plan from eligibility for a health savings account  
23      pursuant to Section 223 of the Internal Revenue Code (26  
24      U.S.C. 223).

25           For purposes of this Section:

26           "Diagnostic mammogram" means a mammogram obtained using

1 diagnostic mammography.

2 "Diagnostic mammography" means a method of screening that  
3 is designed to evaluate an abnormality in a breast, including  
4 an abnormality seen or suspected on a screening mammogram or a  
5 subjective or objective abnormality otherwise detected in the  
6 breast.

7 "Low-dose mammography" means the x-ray examination of the  
8 breast using equipment dedicated specifically for mammography,  
9 including the x-ray tube, filter, compression device, and  
10 image receptor, with radiation exposure delivery of less than  
11 1 rad per breast for 2 views of an average size breast. The  
12 term also includes digital mammography and includes breast  
13 tomosynthesis. As used in this Section, the term "breast  
14 tomosynthesis" means a radiologic procedure that involves the  
15 acquisition of projection images over the stationary breast to  
16 produce cross-sectional digital three-dimensional images of  
17 the breast.

18 If, at any time, the Secretary of the United States  
19 Department of Health and Human Services, or its successor  
20 agency, promulgates rules or regulations to be published in  
21 the Federal Register or publishes a comment in the Federal  
22 Register or issues an opinion, guidance, or other action that  
23 would require the State, pursuant to any provision of the  
24 Patient Protection and Affordable Care Act (Public Law  
25 111-148), including, but not limited to, 42 U.S.C.  
26 18031(d)(3)(B) or any successor provision, to defray the cost

1 of any coverage for breast tomosynthesis outlined in this  
2 subsection, then the requirement that an insurer cover breast  
3 tomosynthesis is inoperative other than any such coverage  
4 authorized under Section 1902 of the Social Security Act, 42  
5 U.S.C. 1396a, and the State shall not assume any obligation  
6 for the cost of coverage for breast tomosynthesis set forth in  
7 this subsection.

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

11 (a-10) When health care services are available through  
12 contracted providers and a person does not comply with plan  
13 provisions specific to the use of contracted providers, the  
14 requirements of subsection (a-5) are not applicable. When a  
15 person does not comply with plan provisions specific to the  
16 use of contracted providers, plan provisions specific to the  
17 use of non-contracted providers must be applied without  
18 distinction for coverage required by this Section and shall be  
19 at least as favorable as for other radiological examinations  
20 covered by the policy or contract.

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

1 shall include:

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

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

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

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

21 Written notice of the availability of coverage under this  
22 Section shall be delivered to the insured upon enrollment and  
23 annually thereafter. An insurer may not deny to an insured  
24 eligibility, or continued eligibility, to enroll or to renew  
25 coverage under the terms of the plan solely for the purpose of  
26 avoiding the requirements of this Section. An insurer may not

1 penalize or reduce or limit the reimbursement of an attending  
2 provider or provide incentives (monetary or otherwise) to an  
3 attending provider to induce the provider to provide care to  
4 an insured in a manner inconsistent with this Section.

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

11 (Source: P.A. 100-395, eff. 1-1-18; 101-580, eff. 1-1-20.)

12 Section 20. The Health Maintenance Organization Act is  
13 amended by changing Section 4-6.1 as follows:

14 (215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)

15 Sec. 4-6.1. Mammograms; mastectomies.

16 (a) Every contract or evidence of coverage issued by a  
17 Health Maintenance Organization for persons who are residents  
18 of this State shall contain coverage for screening by low-dose  
19 mammography for all patients ~~women~~ 35 years of age or older for  
20 the presence of occult breast cancer. The coverage shall be as  
21 follows:

22 (1) A baseline mammogram for patients ~~women~~ 35 to 39  
23 years of age.

24 (2) An annual mammogram for patients ~~women~~ 40 years of

1 age or older.

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

8 (4) For an individual or group policy of accident and  
9 health insurance or a managed care plan that is amended,  
10 delivered, issued, or renewed on or after January 1, 2020  
11 (the effective date of Public Act 101-580) ~~this amendatory~~  
12 ~~Act of the 101st General Assembly,~~ a comprehensive  
13 ultrasound screening and MRI of an entire breast or  
14 breasts if a mammogram demonstrates heterogeneous or dense  
15 breast tissue or when medically necessary as determined by  
16 a physician licensed to practice medicine in all of its  
17 branches.

18 (4.5) For a group policy of accident and health  
19 insurance that is amended, delivered, issued, or renewed  
20 on or after the effective date of this amendatory Act of  
21 the 103rd General Assembly, molecular breast imaging (MBI)  
22 of an entire breast or breasts if a mammogram demonstrates  
23 heterogeneous or dense breast tissue or when medically  
24 necessary as determined by a physician licensed to  
25 practice medicine in all of its branches.

26 (5) For an individual or group policy of accident and

1 health insurance or a managed care plan that is amended,  
2 delivered, issued, or renewed on or after January 1, 2020  
3 (the effective date of Public Act 101-580) ~~this amendatory~~  
4 ~~Act of the 101st General Assembly~~, a diagnostic mammogram  
5 when medically necessary, as determined by a physician  
6 licensed to practice medicine in all its branches,  
7 advanced practice registered nurse, or physician  
8 assistant.

9 A policy subject to this subsection shall not impose a  
10 deductible, coinsurance, copayment, or any other cost-sharing  
11 requirement on the coverage provided; except that this  
12 sentence does not apply to coverage of diagnostic mammograms  
13 to the extent such coverage would disqualify a high-deductible  
14 health plan from eligibility for a health savings account  
15 pursuant to Section 223 of the Internal Revenue Code (26  
16 U.S.C. 223).

17 For purposes of this Section:

18 "Diagnostic mammogram" means a mammogram obtained using  
19 diagnostic mammography.

20 "Diagnostic mammography" means a method of screening that  
21 is designed to evaluate an abnormality in a breast, including  
22 an abnormality seen or suspected on a screening mammogram or a  
23 subjective or objective abnormality otherwise detected in the  
24 breast.

25 "Low-dose mammography" means the x-ray examination of the  
26 breast using equipment dedicated specifically for mammography,

1 including the x-ray tube, filter, compression device, and  
2 image receptor, with radiation exposure delivery of less than  
3 1 rad per breast for 2 views of an average size breast. The  
4 term also includes digital mammography and includes breast  
5 tomosynthesis.

6 "Breast tomosynthesis" means a radiologic procedure that  
7 involves the acquisition of projection images over the  
8 stationary breast to produce cross-sectional digital  
9 three-dimensional images of the breast.

10 If, at any time, the Secretary of the United States  
11 Department of Health and Human Services, or its successor  
12 agency, promulgates rules or regulations to be published in  
13 the Federal Register or publishes a comment in the Federal  
14 Register or issues an opinion, guidance, or other action that  
15 would require the State, pursuant to any provision of the  
16 Patient Protection and Affordable Care Act (Public Law  
17 111-148), including, but not limited to, 42 U.S.C.  
18 18031(d)(3)(B) or any successor provision, to defray the cost  
19 of any coverage for breast tomosynthesis outlined in this  
20 subsection, then the requirement that an insurer cover breast  
21 tomosynthesis is inoperative other than any such coverage  
22 authorized under Section 1902 of the Social Security Act, 42  
23 U.S.C. 1396a, and the State shall not assume any obligation  
24 for the cost of coverage for breast tomosynthesis set forth in  
25 this subsection.

26 (a-5) Coverage as described in subsection (a) shall be



1 provided at no cost to the enrollee and shall not be applied to  
2 an annual or lifetime maximum benefit.

3 (b) No contract or evidence of coverage issued by a health  
4 maintenance organization that provides for the surgical  
5 procedure known as a mastectomy shall be issued, amended,  
6 delivered, or renewed in this State on or after July 3, 2001  
7 ~~(the effective date of Public Act 92-0048) this amendatory Act~~  
8 ~~of the 92nd General Assembly~~ unless that coverage also  
9 provides for prosthetic devices or reconstructive surgery  
10 incident to the mastectomy, providing that the mastectomy is  
11 performed after July 3, 2001 ~~the effective date of this~~  
12 ~~amendatory Act~~. Coverage for breast reconstruction in  
13 connection with a mastectomy shall include:

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

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

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

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

1 evidence of malignancy, then the offered coverage may be  
2 limited to the provision of prosthetic devices and  
3 reconstructive surgery to within 2 years after the date of the  
4 mastectomy. As used in this Section, "mastectomy" means the  
5 removal of all or part of the breast for medically necessary  
6 reasons, as determined by a licensed physician.

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

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

25 (Source: P.A. 100-395, eff. 1-1-18; 101-580, eff. 1-1-20.)

1           Section 25. The Illinois Public Aid Code is amended by  
2 changing Section 5-5 as follows:

3           (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

1 optometrist, whichever the person may select; (13) other  
2 diagnostic, screening, preventive, and rehabilitative  
3 services, including to ensure that the individual's need for  
4 intervention or treatment of mental disorders or substance use  
5 disorders or co-occurring mental health and substance use  
6 disorders is determined using a uniform screening, assessment,  
7 and evaluation process inclusive of criteria, for children and  
8 adults; for purposes of this item (13), a uniform screening,  
9 assessment, and evaluation process refers to a process that  
10 includes an appropriate evaluation and, as warranted, a  
11 referral; "uniform" does not mean the use of a singular  
12 instrument, tool, or process that all must utilize; (14)  
13 transportation and such other expenses as may be necessary;  
14 (15) medical treatment of sexual assault survivors, as defined  
15 in Section 1a of the Sexual Assault Survivors Emergency  
16 Treatment Act, for injuries sustained as a result of the  
17 sexual assault, including examinations and laboratory tests to  
18 discover evidence which may be used in criminal proceedings  
19 arising from the sexual assault; (16) the diagnosis and  
20 treatment of sickle cell anemia; (16.5) services performed by  
21 a chiropractic physician licensed under the Medical Practice  
22 Act of 1987 and acting within the scope of his or her license,  
23 including, but not limited to, chiropractic manipulative  
24 treatment; and (17) any other medical care, and any other type  
25 of remedial care recognized under the laws of this State. The  
26 term "any other type of remedial care" shall include nursing

1 care and nursing home service for persons who rely on  
2 treatment by spiritual means alone through prayer for healing.

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

10 Notwithstanding any other provision of this Code,  
11 reproductive health care that is otherwise legal in Illinois  
12 shall be covered under the medical assistance program for  
13 persons who are otherwise eligible for medical assistance  
14 under this Article.

15 Notwithstanding any other provision of this Section, all  
16 tobacco cessation medications approved by the United States  
17 Food and Drug Administration and all individual and group  
18 tobacco cessation counseling services and telephone-based  
19 counseling services and tobacco cessation medications provided  
20 through the Illinois Tobacco Quitline shall be covered under  
21 the medical assistance program for persons who are otherwise  
22 eligible for assistance under this Article. The Department  
23 shall comply with all federal requirements necessary to obtain  
24 federal financial participation, as specified in 42 CFR  
25 433.15(b)(7), for telephone-based counseling services provided  
26 through the Illinois Tobacco Quitline, including, but not

1 limited to: (i) entering into a memorandum of understanding or  
2 interagency agreement with the Department of Public Health, as  
3 administrator of the Illinois Tobacco Quitline; and (ii)  
4 developing a cost allocation plan for Medicaid-allowable  
5 Illinois Tobacco Quitline services in accordance with 45 CFR  
6 95.507. The Department shall submit the memorandum of  
7 understanding or interagency agreement, the cost allocation  
8 plan, and all other necessary documentation to the Centers for  
9 Medicare and Medicaid Services for review and approval.  
10 Coverage under this paragraph shall be contingent upon federal  
11 approval.

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

19 Upon receipt of federal approval of an amendment to the  
20 Illinois Title XIX State Plan for this purpose, the Department  
21 shall authorize the Chicago Public Schools (CPS) to procure a  
22 vendor or vendors to manufacture eyeglasses for individuals  
23 enrolled in a school within the CPS system. CPS shall ensure  
24 that its vendor or vendors are enrolled as providers in the  
25 medical assistance program and in any capitated Medicaid  
26 managed care entity (MCE) serving individuals enrolled in a

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

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

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

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

22 On and after July 1, 2018, the Department of Healthcare  
23 and Family Services shall provide dental services to any adult  
24 who is otherwise eligible for assistance under the medical  
25 assistance program. As used in this paragraph, "dental  
26 services" means diagnostic, preventative, restorative, or

1 corrective procedures, including procedures and services for  
2 the prevention and treatment of periodontal disease and dental  
3 caries disease, provided by an individual who is licensed to  
4 practice dentistry or dental surgery or who is under the  
5 supervision of a dentist in the practice of his or her  
6 profession.

7 On and after July 1, 2018, targeted dental services, as  
8 set forth in Exhibit D of the Consent Decree entered by the  
9 United States District Court for the Northern District of  
10 Illinois, Eastern Division, in the matter of Memisovski v.  
11 Maram, Case No. 92 C 1982, that are provided to adults under  
12 the medical assistance program shall be established at no less  
13 than the rates set forth in the "New Rate" column in Exhibit D  
14 of the Consent Decree for targeted dental services that are  
15 provided to persons under the age of 18 under the medical  
16 assistance program.

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



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

4 On and after January 1, 2022, the Department of Healthcare  
5 and Family Services shall administer and regulate a  
6 school-based dental program that allows for the out-of-office  
7 delivery of preventative dental services in a school setting  
8 to children under 19 years of age. The Department shall  
9 establish, by rule, guidelines for participation by providers  
10 and set requirements for follow-up referral care based on the  
11 requirements established in the Dental Office Reference Manual  
12 published by the Department that establishes the requirements  
13 for dentists participating in the All Kids Dental School  
14 Program. Every effort shall be made by the Department when  
15 developing the program requirements to consider the different  
16 geographic differences of both urban and rural areas of the  
17 State for initial treatment and necessary follow-up care. No  
18 provider shall be charged a fee by any unit of local government  
19 to participate in the school-based dental program administered  
20 by the Department. Nothing in this paragraph shall be  
21 construed to limit or preempt a home rule unit's or school  
22 district's authority to establish, change, or administer a  
23 school-based dental program in addition to, or independent of,  
24 the school-based dental program administered by the  
25 Department.

26 The Illinois Department, by rule, may distinguish and

1 classify the medical services to be provided only in  
2 accordance with the classes of persons designated in Section  
3 5-2.

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

11 The Illinois Department shall authorize the provision of,  
12 and shall authorize payment for, screening by low-dose  
13 mammography for the presence of occult breast cancer for  
14 individuals 35 years of age or older who are eligible for  
15 medical assistance under this Article, as follows:

16 (A) A baseline mammogram for individuals 35 to 39  
17 years of age.

18 (B) An annual mammogram for individuals 40 years of  
19 age or older.

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

26 (D) A comprehensive ultrasound screening, molecular

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

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

9           (F) A diagnostic mammogram when medically necessary,  
10      as determined by a physician licensed to practice medicine  
11      in all its branches, advanced practice registered nurse,  
12      or physician assistant.

13       The Department shall not impose a deductible, coinsurance,  
14      copayment, or any other cost-sharing requirement on the  
15      coverage provided under this paragraph; except that this  
16      sentence does not apply to coverage of diagnostic mammograms  
17      to the extent such coverage would disqualify a high-deductible  
18      health plan from eligibility for a health savings account  
19      pursuant to Section 223 of the Internal Revenue Code (26  
20      U.S.C. 223).

21       All screenings shall include a physical breast exam,  
22      instruction on self-examination and information regarding the  
23      frequency of self-examination and its value as a preventative  
24      tool.

25       For purposes of this Section:

26       "Diagnostic mammogram" means a mammogram obtained using

1 diagnostic mammography.

2 "Diagnostic mammography" means a method of screening that  
3 is designed to evaluate an abnormality in a breast, including  
4 an abnormality seen or suspected on a screening mammogram or a  
5 subjective or objective abnormality otherwise detected in the  
6 breast.

7 "Low-dose mammography" means the x-ray examination of the  
8 breast using equipment dedicated specifically for mammography,  
9 including the x-ray tube, filter, compression device, and  
10 image receptor, with an average radiation exposure delivery of  
11 less than one rad per breast for 2 views of an average size  
12 breast. The term also includes digital mammography and  
13 includes breast tomosynthesis.

14 "Breast tomosynthesis" means a radiologic procedure that  
15 involves the acquisition of projection images over the  
16 stationary breast to produce cross-sectional digital  
17 three-dimensional images of the breast.

18 If, at any time, the Secretary of the United States  
19 Department of Health and Human Services, or its successor  
20 agency, promulgates rules or regulations to be published in  
21 the Federal Register or publishes a comment in the Federal  
22 Register or issues an opinion, guidance, or other action that  
23 would require the State, pursuant to any provision of the  
24 Patient Protection and Affordable Care Act (Public Law  
25 111-148), including, but not limited to, 42 U.S.C.  
26 18031(d)(3)(B) or any successor provision, to defray the cost

1 of any coverage for breast tomosynthesis outlined in this  
2 paragraph, then the requirement that an insurer cover breast  
3 tomosynthesis is inoperative other than any such coverage  
4 authorized under Section 1902 of the Social Security Act, 42  
5 U.S.C. 1396a, and the State shall not assume any obligation  
6 for the cost of coverage for breast tomosynthesis set forth in  
7 this paragraph.

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

13 On and after January 1, 2012, providers participating in a  
14 quality improvement program approved by the Department shall  
15 be reimbursed for screening and diagnostic mammography at the  
16 same rate as the Medicare program's rates, including the  
17 increased reimbursement for digital mammography and, after  
18 January 1, 2023 (the effective date of Public Act 102-1018)  
19 ~~this amendatory Act of the 102nd General Assembly~~, breast  
20 tomosynthesis.

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

25 On and after January 1, 2017, providers participating in a  
26 breast cancer treatment quality improvement program approved

1 by the Department shall be reimbursed for breast cancer  
2 treatment at a rate that is no lower than 95% of the Medicare  
3 program's rates for the data elements included in the breast  
4 cancer treatment quality program.

5 The Department shall convene an expert panel, including  
6 representatives of hospitals, free-standing breast cancer  
7 treatment centers, breast cancer quality organizations, and  
8 doctors, including radiologists that are trained in all forms  
9 of FDA approved breast imaging technologies, breast surgeons,  
10 reconstructive breast surgeons, oncologists, and primary care  
11 providers to establish quality standards for breast cancer  
12 treatment.

13 Subject to federal approval, the Department shall  
14 establish a rate methodology for mammography at federally  
15 qualified health centers and other encounter-rate clinics.  
16 These clinics or centers may also collaborate with other  
17 hospital-based mammography facilities. By January 1, 2016, the  
18 Department shall report to the General Assembly on the status  
19 of the provision set forth in this paragraph.

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

1 their effectiveness and modifying the methodology based on the  
2 evaluation.

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

9 The Department shall devise a means of case-managing or  
10 patient navigation for beneficiaries diagnosed with breast  
11 cancer. This program shall initially operate as a pilot  
12 program in areas of the State with the highest incidence of  
13 mortality related to breast cancer. At least one pilot program  
14 site shall be in the metropolitan Chicago area and at least one  
15 site shall be outside the metropolitan Chicago area. On or  
16 after July 1, 2016, the pilot program shall be expanded to  
17 include one site in western Illinois, one site in southern  
18 Illinois, one site in central Illinois, and 4 sites within  
19 metropolitan Chicago. An evaluation of the pilot program shall  
20 be carried out measuring health outcomes and cost of care for  
21 those served by the pilot program compared to similarly  
22 situated patients who are not served by the pilot program.

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

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

5 The Department shall provide coverage and reimbursement  
6 for a human papillomavirus (HPV) vaccine that is approved for  
7 marketing by the federal Food and Drug Administration for all  
8 persons between the ages of 9 and 45 and persons of the age of  
9 46 and above who have been diagnosed with cervical dysplasia  
10 with a high risk of recurrence or progression. The Department  
11 shall disallow any preauthorization requirements for the  
12 administration of the human papillomavirus (HPV) vaccine.

13 On or after July 1, 2022, individuals who are otherwise  
14 eligible for medical assistance under this Article shall  
15 receive coverage for perinatal depression screenings for the  
16 12-month period beginning on the last day of their pregnancy.  
17 Medical assistance coverage under this paragraph shall be  
18 conditioned on the use of a screening instrument approved by  
19 the Department.

20 Any medical or health care provider shall immediately  
21 recommend, to any pregnant individual who is being provided  
22 prenatal services and is suspected of having a substance use  
23 disorder as defined in the Substance Use Disorder Act,  
24 referral to a local substance use disorder treatment program  
25 licensed by the Department of Human Services or to a licensed  
26 hospital which provides substance abuse treatment services.



1 The Department of Healthcare and Family Services shall assure  
2 coverage for the cost of treatment of the drug abuse or  
3 addiction for pregnant recipients in accordance with the  
4 Illinois Medicaid Program in conjunction with the Department  
5 of Human Services.

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

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

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

25 The Illinois Department shall establish such regulations  
26 governing the dispensing of health services under this Article

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

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

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

1 the Illinois Health Finance Reform Act, except that:

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

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

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

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

23 Nothing in this Section shall limit the free choice of  
24 practitioners, hospitals, and other providers of medical  
25 services by clients. In order to ensure patient freedom of  
26 choice, the Illinois Department shall immediately promulgate

1 all rules and take all other necessary actions so that  
2 provided services may be accessed from therapeutically  
3 certified optometrists to the full extent of the Illinois  
4 Optometric Practice Act of 1987 without discriminating between  
5 service providers.

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

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

1 assistance under this Code, in accordance with regulations  
2 promulgated by the Illinois Department. The rules and  
3 regulations shall require that proof of the receipt of  
4 prescription drugs, dentures, prosthetic devices and  
5 eyeglasses by eligible persons under this Section accompany  
6 each claim for reimbursement submitted by the dispenser of  
7 such medical services. No such claims for reimbursement shall  
8 be approved for payment by the Illinois Department without  
9 such proof of receipt, unless the Illinois Department shall  
10 have put into effect and shall be operating a system of  
11 post-payment audit and review which shall, on a sampling  
12 basis, be deemed adequate by the Illinois Department to assure  
13 that such drugs, dentures, prosthetic devices and eyeglasses  
14 for which payment is being made are actually being received by  
15 eligible recipients. Within 90 days after September 16, 1984  
16 (the effective date of Public Act 83-1439), the Illinois  
17 Department shall establish a current list of acquisition costs  
18 for all prosthetic devices and any other items recognized as  
19 medical equipment and supplies reimbursable under this Article  
20 and shall update such list on a quarterly basis, except that  
21 the acquisition costs of all prescription drugs shall be  
22 updated no less frequently than every 30 days as required by  
23 Section 5-5.12.

24 Notwithstanding any other law to the contrary, the  
25 Illinois Department shall, within 365 days after July 22, 2013  
26 (the effective date of Public Act 98-104), establish

1 procedures to permit skilled care facilities licensed under  
2 the Nursing Home Care Act to submit monthly billing claims for  
3 reimbursement purposes. Following development of these  
4 procedures, the Department shall, by July 1, 2016, test the  
5 viability of the new system and implement any necessary  
6 operational or structural changes to its information  
7 technology platforms in order to allow for the direct  
8 acceptance and payment of nursing home claims.

9 Notwithstanding any other law to the contrary, the  
10 Illinois Department shall, within 365 days after August 15,  
11 2014 (the effective date of Public Act 98-963), establish  
12 procedures to permit ID/DD facilities licensed under the ID/DD  
13 Community Care Act and MC/DD facilities licensed under the  
14 MC/DD Act to submit monthly billing claims for reimbursement  
15 purposes. Following development of these procedures, the  
16 Department shall have an additional 365 days to test the  
17 viability of the new system and to ensure that any necessary  
18 operational or structural changes to its information  
19 technology platforms are implemented.

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

23 In the case of long term care facilities, within 120  
24 calendar days of receipt by the facility of required  
25 prescreening information, new admissions with associated  
26 admission documents shall be submitted through the Medical

1 Electronic Data Interchange (MEDI) or the Recipient  
2 Eligibility Verification (REV) System or shall be submitted  
3 directly to the Department of Human Services using required  
4 admission forms. Effective September 1, 2014, admission  
5 documents, including all prescreening information, must be  
6 submitted through MEDI or REV. Confirmation numbers assigned  
7 to an accepted transaction shall be retained by a facility to  
8 verify timely submittal. Once an admission transaction has  
9 been completed, all resubmitted claims following prior  
10 rejection are subject to receipt no later than 180 days after  
11 the admission transaction has been completed.

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

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

1 National Practitioner Data Bank (NPDB); program and agency  
2 exclusions; taxpayer identification numbers; tax delinquency;  
3 corporate information; and death records.

4 The Illinois Department shall enter into agreements with  
5 State agencies and departments, and is authorized to enter  
6 into agreements with federal agencies and departments, under  
7 which such agencies and departments shall share data necessary  
8 for medical assistance program integrity functions and  
9 oversight. The Illinois Department shall develop, in  
10 cooperation with other State departments and agencies, and in  
11 compliance with applicable federal laws and regulations,  
12 appropriate and effective methods to share such data. At a  
13 minimum, and to the extent necessary to provide data sharing,  
14 the Illinois Department shall enter into agreements with State  
15 agencies and departments, and is authorized to enter into  
16 agreements with federal agencies and departments, including,  
17 but not limited to: the Secretary of State; the Department of  
18 Revenue; the Department of Public Health; the Department of  
19 Human Services; and the Department of Financial and  
20 Professional Regulation.

21 Beginning in fiscal year 2013, the Illinois Department  
22 shall set forth a request for information to identify the  
23 benefits of a pre-payment, post-adjudication, and post-edit  
24 claims system with the goals of streamlining claims processing  
25 and provider reimbursement, reducing the number of pending or  
26 rejected claims, and helping to ensure a more transparent

1 adjudication process through the utilization of: (i) provider  
2 data verification and provider screening technology; and (ii)  
3 clinical code editing; and (iii) pre-pay, pre-adjudicated ~~pre-~~  
4 or post-adjudicated predictive modeling with an integrated  
5 case management system with link analysis. Such a request for  
6 information shall not be considered as a request for proposal  
7 or as an obligation on the part of the Illinois Department to  
8 take any action or acquire any products or services.

9 The Illinois Department shall establish policies,  
10 procedures, standards and criteria by rule for the  
11 acquisition, repair and replacement of orthotic and prosthetic  
12 devices and durable medical equipment. Such rules shall  
13 provide, but not be limited to, the following services: (1)  
14 immediate repair or replacement of such devices by recipients;  
15 and (2) rental, lease, purchase or lease-purchase of durable  
16 medical equipment in a cost-effective manner, taking into  
17 consideration the recipient's medical prognosis, the extent of  
18 the recipient's needs, and the requirements and costs for  
19 maintaining such equipment. Subject to prior approval, such  
20 rules shall enable a recipient to temporarily acquire and use  
21 alternative or substitute devices or equipment pending repairs  
22 or replacements of any device or equipment previously  
23 authorized for such recipient by the Department.  
24 Notwithstanding any provision of Section 5-5f to the contrary,  
25 the Department may, by rule, exempt certain replacement  
26 wheelchair parts from prior approval and, for wheelchairs,

1 wheelchair parts, wheelchair accessories, and related seating  
2 and positioning items, determine the wholesale price by  
3 methods other than actual acquisition costs.

4 The Department shall require, by rule, all providers of  
5 durable medical equipment to be accredited by an accreditation  
6 organization approved by the federal Centers for Medicare and  
7 Medicaid Services and recognized by the Department in order to  
8 bill the Department for providing durable medical equipment to  
9 recipients. No later than 15 months after the effective date  
10 of the rule adopted pursuant to this paragraph, all providers  
11 must meet the accreditation requirement.

12 In order to promote environmental responsibility, meet the  
13 needs of recipients and enrollees, and achieve significant  
14 cost savings, the Department, or a managed care organization  
15 under contract with the Department, may provide recipients or  
16 managed care enrollees who have a prescription or Certificate  
17 of Medical Necessity access to refurbished durable medical  
18 equipment under this Section (excluding prosthetic and  
19 orthotic devices as defined in the Orthotics, Prosthetics, and  
20 Pedorthics Practice Act and complex rehabilitation technology  
21 products and associated services) through the State's  
22 assistive technology program's reutilization program, using  
23 staff with the Assistive Technology Professional (ATP)  
24 Certification if the refurbished durable medical equipment:  
25 (i) is available; (ii) is less expensive, including shipping  
26 costs, than new durable medical equipment of the same type;

1 (iii) is able to withstand at least 3 years of use; (iv) is  
2 cleaned, disinfected, sterilized, and safe in accordance with  
3 federal Food and Drug Administration regulations and guidance  
4 governing the reprocessing of medical devices in health care  
5 settings; and (v) equally meets the needs of the recipient or  
6 enrollee. The reutilization program shall confirm that the  
7 recipient or enrollee is not already in receipt of the same or  
8 similar equipment from another service provider, and that the  
9 refurbished durable medical equipment equally meets the needs  
10 of the recipient or enrollee. Nothing in this paragraph shall  
11 be construed to limit recipient or enrollee choice to obtain  
12 new durable medical equipment or place any additional prior  
13 authorization conditions on enrollees of managed care  
14 organizations.

15 The Department shall execute, relative to the nursing home  
16 prescreening project, written inter-agency agreements with the  
17 Department of Human Services and the Department on Aging, to  
18 effect the following: (i) intake procedures and common  
19 eligibility criteria for those persons who are receiving  
20 non-institutional services; and (ii) the establishment and  
21 development of non-institutional services in areas of the  
22 State where they are not currently available or are  
23 undeveloped; and (iii) notwithstanding any other provision of  
24 law, subject to federal approval, on and after July 1, 2012, an  
25 increase in the determination of need (DON) scores from 29 to  
26 37 for applicants for institutional and home and

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

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

1           The Illinois Department shall report annually to the  
2 General Assembly, no later than the second Friday in April of  
3 1979 and each year thereafter, in regard to:

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

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

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

10           (d) efforts at utilization review and control by the  
11 Illinois Department.

12           The period covered by each report shall be the 3 years  
13 ending on the June 30 prior to the report. The report shall  
14 include suggested legislation for consideration by the General  
15 Assembly. The requirement for reporting to the General  
16 Assembly shall be satisfied by filing copies of the report as  
17 required by Section 3.1 of the General Assembly Organization  
18 Act, and filing 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.

22           Rulemaking authority to implement Public Act 95-1045, if  
23 any, is conditioned on the rules being adopted in accordance  
24 with all provisions of the Illinois Administrative Procedure  
25 Act and all rules and procedures of the Joint Committee on  
26 Administrative Rules; any purported rule not so adopted, for



1 whatever reason, is unauthorized.

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

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

23 Notwithstanding any other provision of this Code to the  
24 contrary, on or after July 1, 2015, all FDA approved forms of  
25 medication assisted treatment prescribed for the treatment of  
26 alcohol dependence or treatment of opioid dependence shall be

1 covered under both fee for service and managed care medical  
2 assistance programs for persons who are otherwise eligible for  
3 medical assistance under this Article and shall not be subject  
4 to any (1) utilization control, other than those established  
5 under the American Society of Addiction Medicine patient  
6 placement criteria, (2) prior authorization mandate, or (3)  
7 lifetime restriction limit mandate.

8 On or after July 1, 2015, opioid antagonists prescribed  
9 for the treatment of an opioid overdose, including the  
10 medication product, administration devices, and any pharmacy  
11 fees or hospital fees related to the dispensing, distribution,  
12 and administration of the opioid antagonist, shall be covered  
13 under the medical assistance program for persons who are  
14 otherwise eligible for medical assistance under this Article.  
15 As used in this Section, "opioid antagonist" means a drug that  
16 binds to opioid receptors and blocks or inhibits the effect of  
17 opioids acting on those receptors, including, but not limited  
18 to, naloxone hydrochloride or any other similarly acting drug  
19 approved by the U.S. Food and Drug Administration. The  
20 Department shall not impose a copayment on the coverage  
21 provided for naloxone hydrochloride under the medical  
22 assistance program.

23 Upon federal approval, the Department shall provide  
24 coverage and reimbursement for all drugs that are approved for  
25 marketing by the federal Food and Drug Administration and that  
26 are recommended by the federal Public Health Service or the

1 United States Centers for Disease Control and Prevention for  
2 pre-exposure prophylaxis and related pre-exposure prophylaxis  
3 services, including, but not limited to, HIV and sexually  
4 transmitted infection screening, treatment for sexually  
5 transmitted infections, medical monitoring, assorted labs, and  
6 counseling to reduce the likelihood of HIV infection among  
7 individuals who are not infected with HIV but who are at high  
8 risk of HIV infection.

9 A federally qualified health center, as defined in Section  
10 1905(1)(2)(B) of the federal Social Security Act, shall be  
11 reimbursed by the Department in accordance with the federally  
12 qualified health center's encounter rate for services provided  
13 to medical assistance recipients that are performed by a  
14 dental hygienist, as defined under the Illinois Dental  
15 Practice Act, working under the general supervision of a  
16 dentist and employed by a federally qualified health center.

17 Within 90 days after October 8, 2021 (the effective date  
18 of Public Act 102-665), the Department shall seek federal  
19 approval of a State Plan amendment to expand coverage for  
20 family planning services that includes presumptive eligibility  
21 to individuals whose income is at or below 208% of the federal  
22 poverty level. Coverage under this Section shall be effective  
23 beginning no later than December 1, 2022.

24 Subject to approval by the federal Centers for Medicare  
25 and Medicaid Services of a Title XIX State Plan amendment  
26 electing the Program of All-Inclusive Care for the Elderly

1 (PACE) as a State Medicaid option, as provided for by Subtitle  
2 I (commencing with Section 4801) of Title IV of the Balanced  
3 Budget Act of 1997 (Public Law 105-33) and Part 460  
4 (commencing with Section 460.2) of Subchapter E of Title 42 of  
5 the Code of Federal Regulations, PACE program services shall  
6 become a covered benefit of the medical assistance program,  
7 subject to criteria established in accordance with all  
8 applicable laws.

9 Notwithstanding any other provision of this Code,  
10 community-based pediatric palliative care from a trained  
11 interdisciplinary team shall be covered under the medical  
12 assistance program as provided in Section 15 of the Pediatric  
13 Palliative Care Act.

14 Notwithstanding any other provision of this Code, within  
15 12 months after June 2, 2022 (the effective date of Public Act  
16 102-1037) ~~this amendatory Act of the 102nd General Assembly~~  
17 and subject to federal approval, acupuncture services  
18 performed by an acupuncturist licensed under the Acupuncture  
19 Practice Act who is acting within the scope of his or her  
20 license shall be covered under the medical assistance program.  
21 The Department shall apply for any federal waiver or State  
22 Plan amendment, if required, to implement this paragraph. The  
23 Department may adopt any rules, including standards and  
24 criteria, necessary to implement this paragraph.

25 (Source: P.A. 101-209, eff. 8-5-19; 101-580, eff. 1-1-20;  
26 102-43, Article 30, Section 30-5, eff. 7-6-21; 102-43, Article

1 35, Section 35-5, eff. 7-6-21; 102-43, Article 55, Section  
2 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123, eff. 1-1-22;  
3 102-558, eff. 8-20-21; 102-598, eff. 1-1-22; 102-655, eff.  
4 1-1-22; 102-665, eff. 10-8-21; 102-813, eff. 5-13-22;  
5 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22; 102-1038 eff.  
6 1-1-23; revised 2-5-23.)

7 Section 99. Effective date. This Act takes effect upon  
8 becoming law.