

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, advanced practice registered nurse, or physician
9 assistant.

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

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

26 For purposes of this subsection:

1 "Diagnostic mammogram" means a mammogram obtained using
2 diagnostic mammography.

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

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

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

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

1 (d-15) If a county, including a home rule county, is a
2 self-insurer for purposes of providing health insurance
3 coverage for its employees, the insurance coverage shall
4 include mastectomy coverage, which includes coverage for
5 prosthetic devices or reconstructive surgery incident to the
6 mastectomy. Coverage for breast reconstruction in connection
7 with a mastectomy shall include:

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

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

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

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

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

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

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

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

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

1 Illinois Administrative Procedure Act and all rules and
2 procedures of the Joint Committee on Administrative Rules; any
3 purported rule not so adopted, for whatever reason, is
4 unauthorized.

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

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

8 (65 ILCS 5/10-4-2) (from Ch. 24, par. 10-4-2)

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

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

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

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

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

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

1 be as follows:

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

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

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

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

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

1 breast tissue or when medically necessary as determined by
2 a physician licensed to practice medicine in all of its
3 branches, advanced practice registered nurse, or physician
4 assistant.

5 (5) For a group policy of accident and health
6 insurance that is amended, delivered, issued, or renewed
7 on or after January 1, 2020, (the effective date of Public
8 Act 101-580) ~~this amendatory Act of the 101st General~~
9 ~~Assembly,~~ 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 A policy subject to this subsection shall not impose a
14 deductible, coinsurance, copayment, or any other cost-sharing
15 requirement on the coverage provided; 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 For purposes of this subsection:

22 "Diagnostic mammogram" means a mammogram obtained using
23 diagnostic mammography.

24 "Diagnostic mammography" means a method of screening that
25 is designed to evaluate an abnormality in a breast, including
26 an abnormality seen or suspected on a screening mammogram or a

1 subjective or objective abnormality otherwise detected in the
2 breast.

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

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

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

22 (d-15) If a municipality, including a home rule
23 municipality, is a self-insurer for purposes of providing
24 health insurance coverage for its employees, the insurance
25 coverage shall include mastectomy coverage, which includes
26 coverage for prosthetic devices or reconstructive surgery

1 incident to the mastectomy. Coverage for breast reconstruction
2 in connection with a mastectomy shall include:

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

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

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

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

22 A municipality, including a home rule municipality, that
23 is a self-insurer for purposes of providing health insurance
24 coverage for its employees, may not penalize or reduce or
25 limit the reimbursement of an attending provider or provide
26 incentives (monetary or otherwise) to an attending provider to

1 induce the provider to provide care to an insured in a manner
2 inconsistent with this Section.

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

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

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

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

20 (215 ILCS 5/356g) (from Ch. 73, par. 968g)

21 Sec. 356g. Mammograms; mastectomies.

22 (a) Every insurer shall provide in each group or
23 individual policy, contract, or certificate of insurance
24 issued or renewed for persons who are residents of this State,

1 coverage for screening by low-dose mammography for all
2 patients ~~women~~ 35 years of age or older for the presence of
3 occult breast cancer within the provisions of the policy,
4 contract, or certificate. The coverage shall be as follows:

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

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

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

15 (4) For an individual or group policy of accident and
16 health insurance or a managed care plan that is amended,
17 delivered, issued, or renewed on or after January 1, 2020
18 (the effective date of Public Act 101-580) and before the
19 effective date of this amendatory Act of the 103rd General
20 Assembly ~~this amendatory Act of the 101st General~~
21 ~~Assembly~~, a comprehensive ultrasound screening and MRI of
22 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 (4.3) For an individual or group policy of accident

1 and health insurance or a managed care plan that is
2 amended, delivered, issued, or renewed on or after the
3 effective date of this amendatory Act of the 103rd General
4 Assembly, a comprehensive ultrasound screening and MRI of
5 an entire breast or breasts if a mammogram demonstrates
6 heterogeneous or dense breast tissue or when medically
7 necessary as determined by a physician licensed to
8 practice medicine in all of its branches, advanced
9 practice registered nurse, or physician assistant.

10 (4.5) For a group policy of accident and health
11 insurance that is amended, delivered, issued, or renewed
12 on or after the effective date of this amendatory Act of
13 the 103rd General Assembly, molecular breast imaging (MBI)
14 of an entire breast or breasts if a mammogram demonstrates
15 heterogeneous or dense breast tissue or when medically
16 necessary as determined by a physician licensed to
17 practice medicine in all of its branches, advanced
18 practice registered nurse, or physician assistant.

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

22 (6) For an individual or group policy of accident and
23 health insurance or a managed care plan that is amended,
24 delivered, issued, or renewed on or after January 1, 2020
25 (the effective date of Public Act 101-580) ~~this amendatory~~
26 Act of the 101st General Assembly, a diagnostic mammogram

1 when medically necessary, as determined by a physician
2 licensed to practice medicine in all its branches,
3 advanced practice registered nurse, or physician
4 assistant.

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

13 For purposes of this Section:

14 "Diagnostic mammogram" means a mammogram obtained using
15 diagnostic mammography.

16 "Diagnostic mammography" means a method of screening that
17 is designed to evaluate an abnormality in a breast, including
18 an abnormality seen or suspected on a screening mammogram or a
19 subjective or objective abnormality otherwise detected in the
20 breast.

21 "Low-dose mammography" means the x-ray examination of the
22 breast using equipment dedicated specifically for mammography,
23 including the x-ray tube, filter, compression device, and
24 image receptor, with radiation exposure delivery of less than
25 1 rad per breast for 2 views of an average size breast. The
26 term also includes digital mammography and includes breast

1 tomosynthesis. As used in this Section, the term "breast
2 tomosynthesis" means a radiologic procedure that involves the
3 acquisition of projection images over the stationary breast to
4 produce cross-sectional digital three-dimensional images of
5 the breast.

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

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

25 (a-10) When health care services are available through
26 contracted providers and a person does not comply with plan

1 provisions specific to the use of contracted providers, the
2 requirements of subsection (a-5) are not applicable. When a
3 person does not comply with plan provisions specific to the
4 use of contracted providers, plan provisions specific to the
5 use of non-contracted providers must be applied without
6 distinction for coverage required by this Section and shall be
7 at least as favorable as for other radiological examinations
8 covered by the policy or contract.

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

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

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

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

23 Care shall be determined in consultation with the attending
24 physician and the patient. The offered coverage for prosthetic
25 devices and reconstructive surgery shall be subject to the
26 deductible and coinsurance conditions applied to the

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

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

19 (c) Rulemaking authority to implement Public Act 95-1045,
20 if any, is conditioned on the rules being adopted in
21 accordance with all provisions of the Illinois Administrative
22 Procedure Act and all rules and procedures of the Joint
23 Committee on Administrative Rules; any purported rule not so
24 adopted, for whatever reason, is unauthorized.

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

1 Section 20. The Health Maintenance Organization Act is
2 amended by changing Sections 4-6.1 and 5-3 as follows:

3 (215 ILCS 125/4-6.1) (from Ch. 111 1/2, par. 1408.7)

4 Sec. 4-6.1. Mammograms; mastectomies.

5 (a) Every contract or evidence of coverage issued by a
6 Health Maintenance Organization for persons who are residents
7 of this State shall contain coverage for screening by low-dose
8 mammography for all patients ~~women~~ 35 years of age or older for
9 the presence of occult breast cancer. The coverage shall be as
10 follows:

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

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

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

21 (4) For an individual or group policy of accident and
22 health insurance or a managed care plan that is amended,
23 delivered, issued, or renewed on or after January 1, 2020
24 (the effective date of Public Act 101-580) and before the
25 effective date of this amendatory Act of the 103rd General

1 ~~Assembly this amendatory Act of the 101st General~~
2 ~~Assembly,~~ a comprehensive ultrasound screening and MRI of
3 an entire breast or breasts if a mammogram demonstrates
4 heterogeneous or dense breast tissue or when medically
5 necessary as determined by a physician licensed to
6 practice medicine in all of its branches.

7 (4.3) For an individual or group policy of accident
8 and health insurance or a managed care plan that is
9 amended, delivered, issued, or renewed on or after the
10 effective date of this amendatory Act of the 103rd General
11 Assembly, a comprehensive ultrasound screening and MRI of
12 an entire breast or breasts if a mammogram demonstrates
13 heterogeneous or dense breast tissue or when medically
14 necessary as determined by a physician licensed to
15 practice medicine in all of its branches, advanced
16 practice registered nurse, or physician assistant.

17 (4.5) For a group policy of accident and health
18 insurance that is amended, delivered, issued, or renewed
19 on or after the effective date of this amendatory Act of
20 the 103rd General Assembly, molecular breast imaging (MBI)
21 of an 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 (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 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

2 Sec. 5-3. Insurance Code provisions.

3 (a) Health Maintenance Organizations shall be subject to
4 the provisions of Sections 133, 134, 136, 137, 139, 140,
5 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,
6 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49,
7 355.2, 355.3, 355b, 355c, 356f, 356g, 356g.5-1, 356m, 356q,
8 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5,
9 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
10 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21,
11 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29,
12 356z.30, 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34,
13 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.41,
14 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50,
15 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58,
16 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65, 356z.67,
17 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b,
18 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A,
19 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of
20 subsection (2) of Section 367, and Articles IIA, VIII 1/2,
21 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
22 Illinois Insurance Code.

23 (b) For purposes of the Illinois Insurance Code, except
24 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
25 Health Maintenance Organizations in the following categories
26 are deemed to be "domestic companies":

1 (1) a corporation authorized under the Dental Service
2 Plan Act or the Voluntary Health Services Plans Act;

3 (2) a corporation organized under the laws of this
4 State; or

5 (3) a corporation organized under the laws of another
6 state, 30% or more of the enrollees of which are residents
7 of this State, except a corporation subject to
8 substantially the same requirements in its state of
9 organization as is a "domestic company" under Article VIII
10 1/2 of the Illinois Insurance Code.

11 (c) In considering the merger, consolidation, or other
12 acquisition of control of a Health Maintenance Organization
13 pursuant to Article VIII 1/2 of the Illinois Insurance Code,

14 (1) the Director shall give primary consideration to
15 the continuation of benefits to enrollees and the
16 financial conditions of the acquired Health Maintenance
17 Organization after the merger, consolidation, or other
18 acquisition of control takes effect;

19 (2) (i) the criteria specified in subsection (1) (b) of
20 Section 131.8 of the Illinois Insurance Code shall not
21 apply and (ii) the Director, in making his determination
22 with respect to the merger, consolidation, or other
23 acquisition of control, need not take into account the
24 effect on competition of the merger, consolidation, or
25 other acquisition of control;

26 (3) the Director shall have the power to require the

1 following information:

2 (A) certification by an independent actuary of the
3 adequacy of the reserves of the Health Maintenance
4 Organization sought to be acquired;

5 (B) pro forma financial statements reflecting the
6 combined balance sheets of the acquiring company and
7 the Health Maintenance Organization sought to be
8 acquired as of the end of the preceding year and as of
9 a date 90 days prior to the acquisition, as well as pro
10 forma financial statements reflecting projected
11 combined operation for a period of 2 years;

12 (C) a pro forma business plan detailing an
13 acquiring party's plans with respect to the operation
14 of the Health Maintenance Organization sought to be
15 acquired for a period of not less than 3 years; and

16 (D) such other information as the Director shall
17 require.

18 (d) The provisions of Article VIII 1/2 of the Illinois
19 Insurance Code and this Section 5-3 shall apply to the sale by
20 any health maintenance organization of greater than 10% of its
21 enrollee population (including, without limitation, the health
22 maintenance organization's right, title, and interest in and
23 to its health care certificates).

24 (e) In considering any management contract or service
25 agreement subject to Section 141.1 of the Illinois Insurance
26 Code, the Director (i) shall, in addition to the criteria

1 specified in Section 141.2 of the Illinois Insurance Code,
2 take into account the effect of the management contract or
3 service agreement on the continuation of benefits to enrollees
4 and the financial condition of the health maintenance
5 organization to be managed or serviced, and (ii) need not take
6 into account the effect of the management contract or service
7 agreement on competition.

8 (f) Except for small employer groups as defined in the
9 Small Employer Rating, Renewability and Portability Health
10 Insurance Act and except for medicare supplement policies as
11 defined in Section 363 of the Illinois Insurance Code, a
12 Health Maintenance Organization may by contract agree with a
13 group or other enrollment unit to effect refunds or charge
14 additional premiums under the following terms and conditions:

15 (i) the amount of, and other terms and conditions with
16 respect to, the refund or additional premium are set forth
17 in the group or enrollment unit contract agreed in advance
18 of the period for which a refund is to be paid or
19 additional premium is to be charged (which period shall
20 not be less than one year); and

21 (ii) the amount of the refund or additional premium
22 shall not exceed 20% of the Health Maintenance
23 Organization's profitable or unprofitable experience with
24 respect to the group or other enrollment unit for the
25 period (and, for purposes of a refund or additional
26 premium, the profitable or unprofitable experience shall

1 be calculated taking into account a pro rata share of the
2 Health Maintenance Organization's administrative and
3 marketing expenses, but shall not include any refund to be
4 made or additional premium to be paid pursuant to this
5 subsection (f)). The Health Maintenance Organization and
6 the group or enrollment unit may agree that the profitable
7 or unprofitable experience may be calculated taking into
8 account the refund period and the immediately preceding 2
9 plan years.

10 The Health Maintenance Organization shall include a
11 statement in the evidence of coverage issued to each enrollee
12 describing the possibility of a refund or additional premium,
13 and upon request of any group or enrollment unit, provide to
14 the group or enrollment unit a description of the method used
15 to calculate (1) the Health Maintenance Organization's
16 profitable experience with respect to the group or enrollment
17 unit and the resulting refund to the group or enrollment unit
18 or (2) the Health Maintenance Organization's unprofitable
19 experience with respect to the group or enrollment unit and
20 the resulting additional premium to be paid by the group or
21 enrollment unit.

22 In no event shall the Illinois Health Maintenance
23 Organization Guaranty Association be liable to pay any
24 contractual obligation of an insolvent organization to pay any
25 refund authorized under this Section.

26 (g) Rulemaking authority to implement Public Act 95-1045,

1 if any, is conditioned on the rules being adopted in
2 accordance with all provisions of the Illinois Administrative
3 Procedure Act and all rules and procedures of the Joint
4 Committee on Administrative Rules; any purported rule not so
5 adopted, for whatever reason, is unauthorized.

6 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
7 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
8 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
9 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
10 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
11 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
12 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
13 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
14 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
15 eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

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

18 (305 ILCS 5/5-5)

19 Sec. 5-5. Medical services. The Illinois Department, by
20 rule, shall determine the quantity and quality of and the rate
21 of reimbursement for the medical assistance for which payment
22 will be authorized, and the medical services to be provided,
23 which may include all or part of the following: (1) inpatient
24 hospital services; (2) outpatient hospital services; (3) other

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

1 referral; "uniform" does not mean the use of a singular
2 instrument, tool, or process that all must utilize; (14)
3 transportation and such other expenses as may be necessary;
4 (15) medical treatment of sexual assault survivors, as defined
5 in Section 1a of the Sexual Assault Survivors Emergency
6 Treatment Act, for injuries sustained as a result of the
7 sexual assault, including examinations and laboratory tests to
8 discover evidence which may be used in criminal proceedings
9 arising from the sexual assault; (16) the diagnosis and
10 treatment of sickle cell anemia; (16.5) services performed by
11 a chiropractic physician licensed under the Medical Practice
12 Act of 1987 and acting within the scope of his or her license,
13 including, but not limited to, chiropractic manipulative
14 treatment; and (17) any other medical care, and any other type
15 of remedial care recognized under the laws of this State. The
16 term "any other type of remedial care" shall include nursing
17 care and nursing home service for persons who rely on
18 treatment by spiritual means alone through prayer for healing.

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

26 Notwithstanding any other provision of this Code,

1 reproductive health care that is otherwise legal in Illinois
2 shall be covered under the medical assistance program for
3 persons who are otherwise eligible for medical assistance
4 under this Article.

5 Notwithstanding any other provision of this Section, all
6 tobacco cessation medications approved by the United States
7 Food and Drug Administration and all individual and group
8 tobacco cessation counseling services and telephone-based
9 counseling services and tobacco cessation medications provided
10 through the Illinois Tobacco Quitline shall be covered under
11 the medical assistance program for persons who are otherwise
12 eligible for assistance under this Article. The Department
13 shall comply with all federal requirements necessary to obtain
14 federal financial participation, as specified in 42 CFR
15 433.15(b)(7), for telephone-based counseling services provided
16 through the Illinois Tobacco Quitline, including, but not
17 limited to: (i) entering into a memorandum of understanding or
18 interagency agreement with the Department of Public Health, as
19 administrator of the Illinois Tobacco Quitline; and (ii)
20 developing a cost allocation plan for Medicaid-allowable
21 Illinois Tobacco Quitline services in accordance with 45 CFR
22 95.507. The Department shall submit the memorandum of
23 understanding or interagency agreement, the cost allocation
24 plan, and all other necessary documentation to the Centers for
25 Medicare and Medicaid Services for review and approval.
26 Coverage under this paragraph shall be contingent upon federal

1 approval.

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

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

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

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

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

12 On and after July 1, 2018, the Department of Healthcare
13 and Family Services shall provide dental services to any adult
14 who is otherwise eligible for assistance under the medical
15 assistance program. As used in this paragraph, "dental
16 services" means diagnostic, preventative, restorative, or
17 corrective procedures, including procedures and services for
18 the prevention and treatment of periodontal disease and dental
19 caries disease, provided by an individual who is licensed to
20 practice dentistry or dental surgery or who is under the
21 supervision of a dentist in the practice of his or her
22 profession.

23 On and after July 1, 2018, targeted dental services, as
24 set forth in Exhibit D of the Consent Decree entered by the
25 United States District Court for the Northern District of
26 Illinois, Eastern Division, in the matter of Memisovski v.

1 Maram, Case No. 92 C 1982, that are provided to adults under
2 the medical assistance program shall be established at no less
3 than the rates set forth in the "New Rate" column in Exhibit D
4 of the Consent Decree for targeted dental services that are
5 provided to persons under the age of 18 under the medical
6 assistance program.

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

20 On and after January 1, 2022, the Department of Healthcare
21 and Family Services shall administer and regulate a
22 school-based dental program that allows for the out-of-office
23 delivery of preventative dental services in a school setting
24 to children under 19 years of age. The Department shall
25 establish, by rule, guidelines for participation by providers
26 and set requirements for follow-up referral care based on the

1 requirements established in the Dental Office Reference Manual
2 published by the Department that establishes the requirements
3 for dentists participating in the All Kids Dental School
4 Program. Every effort shall be made by the Department when
5 developing the program requirements to consider the different
6 geographic differences of both urban and rural areas of the
7 State for initial treatment and necessary follow-up care. No
8 provider shall be charged a fee by any unit of local government
9 to participate in the school-based dental program administered
10 by the Department. Nothing in this paragraph shall be
11 construed to limit or preempt a home rule unit's or school
12 district's authority to establish, change, or administer a
13 school-based dental program in addition to, or independent of,
14 the school-based dental program administered by the
15 Department.

16 The Illinois Department, by rule, may distinguish and
17 classify the medical services to be provided only in
18 accordance with the classes of persons designated in Section
19 5-2.

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

1 The Illinois Department shall authorize the provision of,
2 and shall authorize payment for, screening by low-dose
3 mammography for the presence of occult breast cancer for
4 individuals 35 years of age or older who are eligible for
5 medical assistance under this Article, as follows:

6 (A) A baseline mammogram for individuals 35 to 39
7 years of age.

8 (B) An annual mammogram for individuals 40 years of
9 age or older.

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

16 (D) A comprehensive ultrasound screening and MRI of an
17 entire breast or breasts if a mammogram demonstrates
18 heterogeneous or dense breast tissue or when medically
19 necessary as determined by a physician licensed to
20 practice medicine in all of its branches.

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

24 (F) A diagnostic mammogram when medically necessary,
25 as determined by a physician licensed to practice medicine
26 in all its branches, advanced practice registered nurse,

1 or physician assistant.

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

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

16 All screenings shall include a physical breast exam,
17 instruction on self-examination and information regarding the
18 frequency of self-examination and its value as a preventative
19 tool.

20 For purposes of this Section:

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

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

1 breast.

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

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

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

1 for the cost of coverage for breast tomosynthesis set forth in
2 this paragraph.

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

8 On and after January 1, 2012, providers participating in a
9 quality improvement program approved by the Department shall
10 be reimbursed for screening and diagnostic mammography at the
11 same rate as the Medicare program's rates, including the
12 increased reimbursement for digital mammography and, after
13 January 1, 2023 (the effective date of Public Act 102-1018),
14 breast tomosynthesis.

15 The Department shall convene an expert panel including
16 representatives of hospitals, free-standing mammography
17 facilities, and doctors, including radiologists, to establish
18 quality standards for mammography.

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

25 The Department shall convene an expert panel, including
26 representatives of hospitals, free-standing breast cancer

1 treatment centers, breast cancer quality organizations, and
2 doctors, including radiologists that are trained in all forms
3 of FDA approved breast imaging technologies, breast surgeons,
4 reconstructive breast surgeons, oncologists, and primary care
5 providers to establish quality standards for breast cancer
6 treatment.

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

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

23 The Department shall establish a performance goal for
24 primary care providers with respect to their female patients
25 over age 40 receiving an annual mammogram. This performance
26 goal shall be used to provide additional reimbursement in the

1 form of a quality performance bonus to primary care providers
2 who meet that goal.

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

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

25 The Department shall provide coverage and reimbursement
26 for a human papillomavirus (HPV) vaccine that is approved for

1 marketing by the federal Food and Drug Administration for all
2 persons between the ages of 9 and 45. Subject to federal
3 approval, the Department shall provide coverage and
4 reimbursement for a human papillomavirus (HPV) vaccine for
5 persons of the age of 46 and above who have been diagnosed with
6 cervical dysplasia with a high risk of recurrence or
7 progression. The Department shall disallow any
8 preauthorization requirements for the administration of the
9 human papillomavirus (HPV) vaccine.

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

17 Any medical or health care provider shall immediately
18 recommend, to any pregnant individual who is being provided
19 prenatal services and is suspected of having a substance use
20 disorder as defined in the Substance Use Disorder Act,
21 referral to a local substance use disorder treatment program
22 licensed by the Department of Human Services or to a licensed
23 hospital which provides substance abuse treatment services.
24 The Department of Healthcare and Family Services shall assure
25 coverage for the cost of treatment of the drug abuse or
26 addiction for pregnant recipients in accordance with the

1 Illinois Medicaid Program in conjunction with the Department
2 of Human Services.

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

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

18 Neither the Department of Healthcare and Family Services
19 nor the Department of Human Services shall sanction the
20 recipient solely on the basis of the recipient's substance
21 abuse.

22 The Illinois Department shall establish such regulations
23 governing the dispensing of health services under this Article
24 as it shall deem appropriate. The Department should seek the
25 advice of formal professional advisory committees appointed by
26 the Director of the Illinois Department for the purpose of

1 providing regular advice on policy and administrative matters,
2 information dissemination and educational activities for
3 medical and health care providers, and consistency in
4 procedures to the Illinois Department.

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

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

25 (1) Physicians participating in a Partnership and
26 providing certain services, which shall be determined by

1 the Illinois Department, to persons in areas covered by
2 the Partnership may receive an additional surcharge for
3 such services.

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

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

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

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

1 Optometric Practice Act of 1987 without discriminating between
2 service providers.

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

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

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

21 Notwithstanding any other law to the contrary, the
22 Illinois Department shall, within 365 days after July 22, 2013
23 (the effective date of Public Act 98-104), establish
24 procedures to permit skilled care facilities licensed under
25 the Nursing Home Care Act to submit monthly billing claims for
26 reimbursement purposes. Following development of these

1 procedures, the Department shall, by July 1, 2016, test the
2 viability of the new system and implement any necessary
3 operational or structural changes to its information
4 technology platforms in order to allow for the direct
5 acceptance and payment of nursing home claims.

6 Notwithstanding any other law to the contrary, the
7 Illinois Department shall, within 365 days after August 15,
8 2014 (the effective date of Public Act 98-963), establish
9 procedures to permit ID/DD facilities licensed under the ID/DD
10 Community Care Act and MC/DD facilities licensed under the
11 MC/DD Act to submit monthly billing claims for reimbursement
12 purposes. Following development of these procedures, the
13 Department shall have an additional 365 days to test the
14 viability of the new system and to ensure that any necessary
15 operational or structural changes to its information
16 technology platforms are implemented.

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

26 The Illinois Department may require that all dispensers of

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

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

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

20 Prior to enrollment and during the conditional enrollment
21 period in the medical assistance program, all vendors shall be
22 subject to enhanced oversight, screening, and review based on
23 the risk of fraud, waste, and abuse that is posed by the
24 category of risk of the vendor. The Illinois Department shall
25 establish the procedures for oversight, screening, and review,
26 which may include, but need not be limited to: criminal and

1 financial background checks; fingerprinting; license,
2 certification, and authorization verifications; unscheduled or
3 unannounced site visits; database checks; prepayment audit
4 reviews; audits; payment caps; payment suspensions; and other
5 screening as required by federal or State law.

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

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

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

1 complete.

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

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

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

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

20 In the case of long term care facilities, within 120
21 calendar days of receipt by the facility of required
22 prescreening information, new admissions with associated
23 admission documents shall be submitted through the Medical
24 Electronic Data Interchange (MEDI) or the Recipient
25 Eligibility Verification (REV) System or shall be submitted
26 directly to the Department of Human Services using required

1 admission forms. Effective September 1, 2014, admission
2 documents, including all prescreening information, must be
3 submitted through MEDI or REV. Confirmation numbers assigned
4 to an accepted transaction shall be retained by a facility to
5 verify timely submittal. Once an admission transaction has
6 been completed, all resubmitted claims following prior
7 rejection are subject to receipt no later than 180 days after
8 the admission transaction has been completed.

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

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

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

18 Beginning in fiscal year 2013, the Illinois Department
19 shall set forth a request for information to identify the
20 benefits of a pre-payment, post-adjudication, and post-edit
21 claims system with the goals of streamlining claims processing
22 and provider reimbursement, reducing the number of pending or
23 rejected claims, and helping to ensure a more transparent
24 adjudication process through the utilization of: (i) provider
25 data verification and provider screening technology; and (ii)
26 clinical code editing; and (iii) pre-pay, pre-adjudicated, or

1 post-adjudicated predictive modeling with an integrated case
2 management system with link analysis. Such a request for
3 information shall not be considered as a request for proposal
4 or as an obligation on the part of the Illinois Department to
5 take any action or acquire any products or services.

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

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

9 In order to promote environmental responsibility, meet the
10 needs of recipients and enrollees, and achieve significant
11 cost savings, the Department, or a managed care organization
12 under contract with the Department, may provide recipients or
13 managed care enrollees who have a prescription or Certificate
14 of Medical Necessity access to refurbished durable medical
15 equipment under this Section (excluding prosthetic and
16 orthotic devices as defined in the Orthotics, Prosthetics, and
17 Pedorthics Practice Act and complex rehabilitation technology
18 products and associated services) through the State's
19 assistive technology program's reutilization program, using
20 staff with the Assistive Technology Professional (ATP)
21 Certification if the refurbished durable medical equipment:
22 (i) is available; (ii) is less expensive, including shipping
23 costs, than new durable medical equipment of the same type;
24 (iii) is able to withstand at least 3 years of use; (iv) is
25 cleaned, disinfected, sterilized, and safe in accordance with
26 federal Food and Drug Administration regulations and guidance

1 governing the reprocessing of medical devices in health care
2 settings; and (v) equally meets the needs of the recipient or
3 enrollee. The reutilization program shall confirm that the
4 recipient or enrollee is not already in receipt of the same or
5 similar equipment from another service provider, and that the
6 refurbished durable medical equipment equally meets the needs
7 of the recipient or enrollee. Nothing in this paragraph shall
8 be construed to limit recipient or enrollee choice to obtain
9 new durable medical equipment or place any additional prior
10 authorization conditions on enrollees of managed care
11 organizations.

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

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

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

24 The Illinois Department shall report annually to the
25 General Assembly, no later than the second Friday in April of
26 1979 and each year thereafter, in regard to:

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

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

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

7 (d) efforts at utilization review and control by the
8 Illinois Department.

9 The period covered by each report shall be the 3 years
10 ending on the June 30 prior to the report. The report shall
11 include suggested legislation for consideration by the General
12 Assembly. The requirement for reporting to the General
13 Assembly shall be satisfied by filing copies of the report as
14 required by Section 3.1 of the General Assembly Organization
15 Act, and filing such additional copies with the State
16 Government Report Distribution Center for the General Assembly
17 as is required under paragraph (t) of Section 7 of the State
18 Library Act.

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

25 On and after July 1, 2012, the Department shall reduce any
26 rate of reimbursement for services or other payments or alter

1 any methodologies authorized by this Code to reduce any rate
2 of reimbursement for services or other payments in accordance
3 with Section 5-5e.

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

20 Notwithstanding any other provision of this Code to the
21 contrary, on or after July 1, 2015, all FDA approved forms of
22 medication assisted treatment prescribed for the treatment of
23 alcohol dependence or treatment of opioid dependence shall be
24 covered under both fee-for-service ~~fee for service~~ and managed
25 care medical assistance programs for persons who are otherwise
26 eligible for medical assistance under this Article and shall

1 not be subject to any (1) utilization control, other than
2 those established under the American Society of Addiction
3 Medicine patient placement criteria, (2) prior authorization
4 mandate, or (3) lifetime restriction limit mandate.

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

20 Upon federal approval, the Department shall provide
21 coverage and reimbursement for all drugs that are approved for
22 marketing by the federal Food and Drug Administration and that
23 are recommended by the federal Public Health Service or the
24 United States Centers for Disease Control and Prevention for
25 pre-exposure prophylaxis and related pre-exposure prophylaxis
26 services, including, but not limited to, HIV and sexually

1 transmitted infection screening, treatment for sexually
2 transmitted infections, medical monitoring, assorted labs, and
3 counseling to reduce the likelihood of HIV infection among
4 individuals who are not infected with HIV but who are at high
5 risk of HIV infection.

6 A federally qualified health center, as defined in Section
7 1905(1)(2)(B) of the federal Social Security Act, shall be
8 reimbursed by the Department in accordance with the federally
9 qualified health center's encounter rate for services provided
10 to medical assistance recipients that are performed by a
11 dental hygienist, as defined under the Illinois Dental
12 Practice Act, working under the general supervision of a
13 dentist and employed by a federally qualified health center.

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

21 Subject to approval by the federal Centers for Medicare
22 and Medicaid Services of a Title XIX State Plan amendment
23 electing the Program of All-Inclusive Care for the Elderly
24 (PACE) as a State Medicaid option, as provided for by Subtitle
25 I (commencing with Section 4801) of Title IV of the Balanced
26 Budget Act of 1997 (Public Law 105-33) and Part 460

1 (commencing with Section 460.2) of Subchapter E of Title 42 of
2 the Code of Federal Regulations, PACE program services shall
3 become a covered benefit of the medical assistance program,
4 subject to criteria established in accordance with all
5 applicable laws.

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

11 Notwithstanding any other provision of this Code, within
12 12 months after June 2, 2022 (the effective date of Public Act
13 102-1037) and subject to federal approval, acupuncture
14 services performed by an acupuncturist licensed under the
15 Acupuncture Practice Act who is acting within the scope of his
16 or her license shall be covered under the medical assistance
17 program. The Department shall apply for any federal waiver or
18 State Plan amendment, if required, to implement this
19 paragraph. The Department may adopt any rules, including
20 standards and criteria, necessary to implement this paragraph.

21 Notwithstanding any other provision of this Code, the
22 medical assistance program shall, subject to appropriation and
23 federal approval, reimburse hospitals for costs associated
24 with a newborn screening test for the presence of
25 metachromatic leukodystrophy, as required under the Newborn
26 Metabolic Screening Act, at a rate not less than the fee

1 charged by the Department of Public Health. The Department
2 shall seek federal approval before the implementation of the
3 newborn screening test fees by the Department of Public
4 Health.

5 Notwithstanding any other provision of this Code,
6 beginning on January 1, 2024, subject to federal approval,
7 cognitive assessment and care planning services provided to a
8 person who experiences signs or symptoms of cognitive
9 impairment, as defined by the Diagnostic and Statistical
10 Manual of Mental Disorders, Fifth Edition, shall be covered
11 under the medical assistance program for persons who are
12 otherwise eligible for medical assistance under this Article.

13 Notwithstanding any other provision of this Code,
14 medically necessary reconstructive services that are intended
15 to restore physical appearance shall be covered under the
16 medical assistance program for persons who are otherwise
17 eligible for medical assistance under this Article. As used in
18 this paragraph, "reconstructive services" means treatments
19 performed on structures of the body damaged by trauma to
20 restore physical appearance.

21 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;
22 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article
23 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,
24 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;
25 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.
26 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;

1 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.
2 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;
3 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.
4 1-1-24; revised 12-15-23.)

5 Section 99. Effective date. This Act takes effect January
6 1, 2026.