

**104TH GENERAL ASSEMBLY****State of Illinois****2025 and 2026****SB3670**

Introduced 2/5/2026, by Sen. Adriane Johnson

SYNOPSIS AS INTRODUCED:

See Index

Creates the Catch Heart Disease Early Act. Provides that all Illinois residents, 20 years of age or older, are entitled to heart disease screenings at no cost according to the following schedule: one screening every 6 years for individuals aged 20 through 39 years; and one screening every 2 years for individuals aged 40 years and older. Provides that no individual shall be charged any co-payment, co-insurance, deductible, out-of-pocket fee, or other cost-sharing amount or required to enter into any cost-sharing agreement in order to access heart disease screenings. Provides that the State of Illinois shall be the payer of last resort and only cover any outstanding screening costs for eligible uninsured or underinsured individuals whose public or private insurance, including Medicaid or Medicare, does not cover the full cost of heart disease screenings. Provides that service providers of heart disease screenings for eligible uninsured or underinsured Illinois residents shall be reimbursed through a voucher program. Requires the Department of Healthcare and Family Services to perform certain functions to implement the Act, including, but not limited to: (i) establishing a confidential registry to track screening dates and prevent duplicate heart disease screenings outside the authorized frequency; and (ii) provide a mechanism for individuals and providers to verify screening eligibility. Requires health care providers to verify an individual's age, residency, date of last heart disease screening, and other matters prior to administering a screening and recording it in the individual's medical record. Contains provisions on Department rules. Provides that, subject to appropriation, the Department shall implement the voucher program by July 1, 2027. Adds conforming language to the State Employees Group Insurance Act, the Counties Code, the Illinois Municipal Code, the School Code, the Illinois Public Aid Code, and the Illinois Insurance Code. Effective immediately.

LRB104 19624 KTG 33073 b

1 AN ACT concerning health care.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 1. Short title. This Act may be cited as the Catch
5 Heart Disease Early Act.

6 Section 5. Findings; purpose:

7 (a) The General Assembly finds that:

8 (1) As of 2022, heart disease is the leading cause of
9 death of Illinois adults.

10 (2) In 2022, 27.5% of all deaths in Illinois were
11 caused by either heart disease or stroke.

12 (3) Americans with income below the 10th percentile
13 were 24% more likely to die from cardiovascular illness
14 than the general population.

15 (4) Attending a heart disease screening is associated
16 with a 62% decrease in cardiovascular mortality and 55%
17 decrease in all-cause mortality.

18 (5) Reduction of out-of-pocket costs has successfully
19 increased uptake of similar screenings for other diseases.

20 (6) These screenings remain highly cost effective by
21 reducing downstream costs to patients and state and
22 federal agencies alike.

23 (b) The General Assembly deems it in the public interest

1 to enact this Act in order to detect heart and other
2 cardiovascular diseases in vulnerable populations and prompt
3 referrals for early treatment and case management programs.

4 Section 10. Definitions. As used in this Act:

5 "Department" means the Department of Healthcare and Family
6 Services.

7 "Heart disease screening" or "screening" means a
8 diagnostic series of tests carried out by a medical
9 professional to assess risk, history, and present condition of
10 cardiovascular disease. "Heart disease screening" or
11 "screening" includes, at a minimum, all of the following
12 diagnostic tools and tests:

13 (1) Blood tests of cholesterol, triglycerides, and
14 blood sugar levels.

15 (2) Blood pressure check.

16 (3) Electrocardiogram.

17 (4) Echocardiogram.

18 (5) Exercise stress test.

19 (6) Coronary calcium scan.

20 Section 15. Annual heart disease screenings; insurance
21 coverage.

22 (a) The Department of Healthcare and Family Services shall
23 establish and implement a heart disease screening and voucher
24 program. Under the program, all Illinois residents 20 years of

1 age or older shall be entitled to heart disease screenings at
2 no cost according to the following schedule:

3 (1) For individuals aged 20 through 39 years: one
4 screening every 6 years.

5 (2) For individuals aged 40 years and older: one
6 screening every 2 years.

7 (b) No individual shall be charged any co-payment,
8 co-insurance, deductible, out-of-pocket fee, or other
9 cost-sharing amount or required to enter into any cost-sharing
10 agreement in order to access heart disease screenings covered
11 under this Act at the frequencies established in subsection
12 (a).

13 (c) The State of Illinois shall be a payer of last resort:

14 (1) For eligible Illinois residents with health
15 insurance coverage, including coverage under Medicare
16 (Title XVIII of the Social Security Act) or Medicaid
17 (Title XIX of the Social Security Act), such coverage
18 shall be the primary payer for heart disease screenings
19 covered under this Act at the frequency specified in
20 subsection (a). The insurer shall pay out the amount
21 consistent with the patient's coverage plan.

22 (2) For eligible Illinois residents whose insurance
23 plans do not cover the full costs of a heart disease
24 screening at a frequency no less than what is required
25 under subsection (a), the Department of Healthcare and
26 Family Services shall allocate the appropriate funding to

1 the service provider through a screening voucher program.

2 (d) Subject to appropriation, the Department shall
3 implement and administer the heart disease screening voucher
4 program by July 1, 2027.

5 Section 20. Implementation.

6 (a) The Department of Healthcare and Family Services
7 shall:

8 (1) establish a confidential registry to track
9 screening dates and prevent duplicate heart disease
10 screenings outside the authorized frequency;

11 (2) provide a mechanism for individuals and providers
12 to verify eligibility for a heart disease screening based
13 on age and date of last screening;

14 (3) ensure the registry complies with all State and
15 federal privacy laws including federal requirements under
16 the Health Insurance Portability and Accountability Act of
17 1996; and

18 (4) allow individuals to opt out of the registry while
19 maintaining eligibility for heart disease screenings.

20 (b) Prior to administering a heart disease screening on an
21 individual in accordance with this Act, providers shall:

22 (1) verify the individual's age and residency in
23 Illinois;

24 (2) verify the date of the individual's last heart
25 disease screening, if any;

1 (3) confirm the individual is eligible for a heart
2 disease screening under the age-based schedule established
3 in subsection (a) of Section 15; and

4 (4) document such verification in the individual's
5 medical record.

6 Section 25. Oversight.

7 (a) The Department shall oversee the implementation of
8 this Act.

9 (b) The Department shall adopt rules to advance the aims
10 of this Act, including, at minimum, the following:

11 (1) Allocate monies appropriated for the purposes of
12 this Act to cover the price of screening vouchers for
13 eligible individuals who are uninsured or underinsured.

14 (2) Coordinate with public and private insurance
15 providers, including Medicaid and Medicare, to ensure that
16 out-of-pocket costs are covered in their entirety and that
17 the State functions as a payer of last resort, with
18 insurance programs serving as the first payer.

19 (3) Communicate with the public, medical service
20 providers, primary physicians, and managed care
21 specialists to inform them of the heart disease screening
22 voucher program.

23 Section 30. Conflict of laws. Where the provisions of this
24 Act conflict with any other law, the provisions of this Act

1 shall control.

2 Section 35. The State Employees Group Insurance Act of
3 1971 is amended by changing Section 6.11 as follows:

4 (5 ILCS 375/6.11)

5 (Text of Section before amendment by P.A. 104-1)

6 Sec. 6.11. Required health benefits; Illinois Insurance
7 Code requirements. The program of health benefits shall
8 provide the post-mastectomy care benefits required to be
9 covered by a policy of accident and health insurance under
10 Section 356t of the Illinois Insurance Code. The program of
11 health benefits shall provide the coverage required under
12 Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10,
13 356w, 356x, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8,
14 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15,
15 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32,
16 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,
17 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59,
18 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.70,
19 356z.71, 356z.74, 356z.76, ~~and~~ 356z.77, ~~and~~ 356z.80, 356z.81,
20 356z.82, 356z.83, 356z.84, and 356z.85 of the Illinois
21 Insurance Code. The program of health benefits must comply
22 with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1
23 and Article XXXIIB of the Illinois Insurance Code. The program
24 of health benefits shall provide the coverage required under

1 Section 356m of the Illinois Insurance Code and, for the
2 employees of the State Employee Group Insurance Program only,
3 the coverage as also provided in Section 6.11B of this Act. The
4 program of health benefits shall provide the coverage required
5 under the Catch Heart Disease Early Act. The Department of
6 Insurance shall enforce the requirements of this Section with
7 respect to Sections 370c and 370c.1 and Article XXXIIB of the
8 Illinois Insurance Code; all other requirements of this
9 Section shall be enforced by the Department of Central
10 Management Services.

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

17 (Source: P.A. 103-8, eff. 1-1-24; 103-84, eff. 1-1-24; 103-91,
18 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
19 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff.
20 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-870,
21 eff. 1-1-25; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25;
22 103-951, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-27, eff.
23 1-1-26, 104-42, eff. 8-1-25; 104-68, eff. 1-1-26; 104-73, eff.
24 1-1-26; 104-289, eff. 1-1-26; 104-324, eff. 1-1-26; 104-379,
25 eff. 1-1-26; 104-417, eff. 8-15-25; revised 11-19-25.)

1 (Text of Section after amendment by P.A. 104-1)

2 Sec. 6.11. Required health benefits; Illinois Insurance
3 Code requirements. The program of health benefits shall
4 provide the post-mastectomy care benefits required to be
5 covered by a policy of accident and health insurance under
6 Section 356t of the Illinois Insurance Code. The program of
7 health benefits shall provide the coverage required under
8 Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10,
9 356w, 356x, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8,
10 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15,
11 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32,
12 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,
13 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.59,
14 356z.60, 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.70,
15 356z.71, 356z.74, 356z.76, ~~and 356z.77, 356z.79, and 356z.80,~~
16 356z.81, 356z.82, 356z.83, 356z.84, and 356z.85 of the
17 Illinois Insurance Code. The program of health benefits must
18 comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and
19 370c.1 and Article XXXIIB of the Illinois Insurance Code. The
20 program of health benefits shall provide the coverage required
21 under Section 356m of the Illinois Insurance Code and, for the
22 employees of the State Employee Group Insurance Program only,
23 the coverage as also provided in Section 6.11B of this Act. The
24 program of health benefits shall provide the coverage required
25 under the Catch Heart Disease Early Act. The Department of
26 Insurance shall enforce the requirements of this Section with

1 respect to Sections 370c and 370c.1 and Article XXXIIB of the
2 Illinois Insurance Code; all other requirements of this
3 Section shall be enforced by the Department of Central
4 Management Services.

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

11 (Source: P.A. 103-8, eff. 1-1-24; 103-84, eff. 1-1-24; 103-91,
12 eff. 1-1-24; 103-420, eff. 1-1-24; 103-445, eff. 1-1-24;
13 103-535, eff. 8-11-23; 103-551, eff. 8-11-23; 103-605, eff.
14 7-1-24; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-870,
15 eff. 1-1-25; 103-914, eff. 1-1-25; 103-918, eff. 1-1-25;
16 103-951, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff.
17 7-1-27; 104-27, eff. 1-1-26, 104-42, eff. 8-1-25; 104-68, eff.
18 1-1-26; 104-73, eff. 1-1-26; 104-289, eff. 1-1-26; 104-324,
19 eff. 1-1-26; 104-379, eff. 1-1-26; 104-417, eff. 8-15-25;
20 revised 11-19-25.)

21 Section 40. The Counties Code is amended by changing
22 Section 5-1069.3 as follows:

23 (55 ILCS 5/5-1069.3)

24 (Text of Section before amendment by P.A. 104-446)

1 Sec. 5-1069.3. Required health benefits. If a county,
2 including a home rule county, is a self-insurer for purposes
3 of providing health insurance coverage for its employees, the
4 coverage shall include coverage for the post-mastectomy care
5 benefits required to be covered by a policy of accident and
6 health insurance under Section 356t and the coverage required
7 under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u,
8 356u.10, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9,
9 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22,
10 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36,
11 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.48, 356z.51,
12 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61,
13 356z.62, 356z.64, 356z.67, 356z.68, 356z.70, 356z.71, 356z.74,
14 ~~and~~ 356z.77, 356z.79, and 356z.80, 356z.81, 356z.82, 356z.83,
15 356z.84, and 356z.85 of the Illinois Insurance Code, and the
16 coverage required under the Catch Heart Disease Early Act. The
17 coverage shall comply with Sections 155.22a, 355b, 356z.19,
18 and 370c of the Illinois Insurance Code. The Department of
19 Insurance shall enforce the requirements of this Section. The
20 requirement that health benefits be covered as provided in
21 this Section is an exclusive power and function of the State
22 and is a denial and limitation under Article VII, Section 6,
23 subsection (h) of the Illinois Constitution. A home rule
24 county to which this Section applies must comply with every
25 provision of this Section.

26 Rulemaking authority to implement Public Act 95-1045, if

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

6 (Source: P.A. 103-84, eff. 1-1-24; 103-91, eff. 1-1-24;
7 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff.
8 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718,
9 eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25;
10 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff.
11 6-9-25; 104-42, eff. 8-1-25; 104-68, eff. 1-1-26; 104-73, eff.
12 1-1-26; 104-289, eff. 1-1-26; 104-324, eff. 1-1-26; 104-379,
13 eff. 1-1-26; 104-417, eff. 8-15-25; revised 1-7-26.)

14 (Text of Section after amendment by P.A. 104-446)

15 Sec. 5-1069.3. Required health benefits. If a county,
16 including a home rule county, is a self-insurer for purposes
17 of providing health insurance coverage for its employees, the
18 coverage shall include coverage for the post-mastectomy care
19 benefits required to be covered by a policy of accident and
20 health insurance under Section 356t and the coverage required
21 under Sections 356g, 356g.5, 356g.5-1, 356m, 356q, 356u,
22 356u.10, 356w, 356x, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9,
23 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22,
24 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 356z.36,
25 356z.40, 356z.41, 356z.45, 356z.46, 356z.47, 356z.48, 356z.51,

1 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60, 356z.61,
2 356z.62, 356z.64, 356z.67, 356z.68, 356z.70, 356z.71, 356z.74,
3 ~~and~~ 356z.77, 356z.79, and 356z.80, 356z.81, 356z.82, 356z.83,
4 356z.84, and 356z.85 of the Illinois Insurance Code, and the
5 coverage required under the Catch Heart Disease Early Act. The
6 coverage shall comply with Sections 155.22a, 355b, 356z.19,
7 370c, and 370c.4 of the Illinois Insurance Code. The
8 Department of Insurance shall enforce the requirements of this
9 Section. The requirement that health benefits be covered as
10 provided in this Section is an exclusive power and function of
11 the State and is a denial and limitation under Article VII,
12 Section 6, subsection (h) of the Illinois Constitution. A home
13 rule county to which this Section applies must comply with
14 every provision of this Section.

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

21 (Source: P.A. 103-84, eff. 1-1-24; 103-91, eff. 1-1-24;
22 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff.
23 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718,
24 eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25;
25 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff.
26 6-9-25; 104-42, eff. 8-1-25; 104-68, eff. 1-1-26; 104-73, eff.

1 1-1-26; 104-289, eff. 1-1-26; 104-324, eff. 1-1-26; 104-379,
2 eff. 1-1-26; 104-417, eff. 8-15-25; 104-446, eff. 6-1-26;
3 revised 1-7-26.)

4 Section 45. The Illinois Municipal Code is amended by
5 changing Section 10-4-2.3 as follows:

6 (65 ILCS 5/10-4-2.3)

7 (Text of Section before amendment by P.A. 104-446)

8 Sec. 10-4-2.3. Required health benefits. If a
9 municipality, including a home rule municipality, is a
10 self-insurer for purposes of providing health insurance
11 coverage for its employees, the coverage shall include
12 coverage for the post-mastectomy care benefits required to be
13 covered by a policy of accident and health insurance under
14 Section 356t and the coverage required under Sections 356g,
15 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x,
16 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11,
17 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26,
18 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41,
19 356z.45, 356z.46, 356z.47, 356z.48, 356z.51, 356z.53, 356z.54,
20 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64,
21 356z.67, 356z.68, 356z.70, 356z.71, 356z.74, ~~and~~ 356z.77,
22 356z.79, ~~and~~ 356z.80, 356z.81, 356z.82, 356z.83, 356z.84, and
23 356z.85 of the Illinois Insurance Code, and the coverage
24 required under the Catch Heart Disease Early Act. The coverage

1 shall comply with Sections 155.22a, 355b, 356z.19, and 370c of
2 the Illinois Insurance Code. The Department of Insurance shall
3 enforce the requirements of this Section. The requirement that
4 health benefits be covered as provided in this Section is an
5 exclusive power and function of the State and is a denial and
6 limitation under Article VII, Section 6, subsection (h) of the
7 Illinois Constitution. A home rule municipality to which this
8 Section applies must comply with every provision of this
9 Section.

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

16 (Source: P.A. 103-84, eff. 1-1-24; 103-91, eff. 1-1-24;
17 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff.
18 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718,
19 eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25;
20 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff.
21 6-9-25; 104-42, eff. 8-1-25; 104-68, eff. 1-1-26; 104-73, eff.
22 1-1-26; 104-289, eff. 1-1-26; 104-324, eff. 1-1-26; 104-379,
23 eff. 1-1-26; 104-417, eff. 8-15-25; revised 1-8-26.)

24 (Text of Section after amendment by P.A. 104-446)

25 Sec. 10-4-2.3. Required health benefits. If a

1 municipality, including a home rule municipality, is a
2 self-insurer for purposes of providing health insurance
3 coverage for its employees, the coverage shall include
4 coverage for the post-mastectomy care benefits required to be
5 covered by a policy of accident and health insurance under
6 Section 356t and the coverage required under Sections 356g,
7 356g.5, 356g.5-1, 356m, 356q, 356u, 356u.10, 356w, 356x,
8 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11,
9 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26,
10 356z.29, 356z.30, 356z.32, 356z.33, 356z.36, 356z.40, 356z.41,
11 356z.45, 356z.46, 356z.47, 356z.48, 356z.51, 356z.53, 356z.54,
12 356z.56, 356z.57, 356z.59, 356z.60, 356z.61, 356z.62, 356z.64,
13 356z.67, 356z.68, 356z.70, 356z.71, 356z.74, ~~and~~ 356z.77,
14 356z.79, ~~and~~ 356z.80, 356z.81, 356z.82, 356z.83, 356z.84, and
15 356z.85 of the Illinois Insurance Code, and the coverage
16 required under the Catch Heart Disease Early Act. The coverage
17 shall comply with Sections 155.22a, 355b, 356z.19, 370c, and
18 370c.4 of the Illinois Insurance Code. The Department of
19 Insurance shall enforce the requirements of this Section. The
20 requirement that health benefits be covered as provided in
21 this Section is an exclusive power and function of the State
22 and is a denial and limitation under Article VII, Section 6,
23 subsection (h) of the Illinois Constitution. A home rule
24 municipality to which this Section applies must comply with
25 every provision of this Section.

26 Rulemaking authority to implement Public Act 95-1045, if

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

6 (Source: P.A. 103-84, eff. 1-1-24; 103-91, eff. 1-1-24;
7 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff.
8 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718,
9 eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25;
10 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff.
11 6-9-25; 104-42, eff. 8-1-25; 104-68, eff. 1-1-26; 104-73, eff.
12 1-1-26; 104-289, eff. 1-1-26; 104-324, eff. 1-1-26; 104-379,
13 eff. 1-1-26; 104-417, eff. 8-15-25; 104-446, eff. 6-1-26;
14 revised 1-8-26.)

15 Section 50. The School Code is amended by changing Section
16 10-22.3f as follows:

17 (105 ILCS 5/10-22.3f)

18 (Text of Section before amendment by P.A. 104-446)

19 Sec. 10-22.3f. Required health benefits. Insurance
20 protection and benefits for employees shall provide the
21 post-mastectomy care benefits required to be covered by a
22 policy of accident and health insurance under Section 356t and
23 the coverage required under Sections 356g, 356g.5, 356g.5-1,
24 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.4, 356z.4a,

1 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14,
2 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32,
3 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,
4 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60,
5 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.70, 356z.71,
6 356z.74, ~~and~~ 356z.77, 356z.79, and 356z.80, 356z.81, 356z.82,
7 356z.83, 356z.84, and 356z.85 of the Illinois Insurance Code,
8 and the coverage required under the Catch Heart Disease Early
9 Act. Insurance policies shall comply with Section 356z.19 of
10 the Illinois Insurance Code. The coverage shall comply with
11 Sections 155.22a, 355b, and 370c and Article XXXIIB of the
12 Illinois Insurance Code. The Department of Insurance shall
13 enforce the requirements of this Section.

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

20 (Source: P.A. 103-84, eff. 1-1-24; 103-91, eff. 1-1-24;
21 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff.
22 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718,
23 eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25;
24 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff.
25 6-9-25; 104-27, eff. 1-1-26; 104-42, eff. 8-1-25; 104-68, eff.
26 1-1-26; 104-73, eff. 1-1-26; 104-289, eff. 1-1-26; 104-324,

1 eff. 1-1-26; 104-379, eff. 1-1-26; 104-417, eff. 8-15-25;
2 revised 1-8-26.)

3 (Text of Section after amendment by P.A. 104-446)

4 Sec. 10-22.3f. Required health benefits. Insurance
5 protection and benefits for employees shall provide the
6 post-mastectomy care benefits required to be covered by a
7 policy of accident and health insurance under Section 356t and
8 the coverage required under Sections 356g, 356g.5, 356g.5-1,
9 356m, 356q, 356u, 356u.10, 356w, 356x, 356z.4, 356z.4a,
10 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14,
11 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32,
12 356z.33, 356z.36, 356z.40, 356z.41, 356z.45, 356z.46, 356z.47,
13 356z.51, 356z.53, 356z.54, 356z.56, 356z.57, 356z.59, 356z.60,
14 356z.61, 356z.62, 356z.64, 356z.67, 356z.68, 356z.70, 356z.71,
15 356z.74, ~~and~~ 356z.77, 356z.79, and 356z.80, 356z.81, 356z.82,
16 356z.83, 356z.84, and 356z.85 of the Illinois Insurance Code,
17 and the coverage required under the Catch Heart Disease Early
18 Act. Insurance policies shall comply with Section 356z.19 of
19 the Illinois Insurance Code. The coverage shall comply with
20 Sections 155.22a, 355b, 370c, and 370c.4 and Article XXXIIB of
21 the Illinois Insurance Code. The Department of Insurance shall
22 enforce the requirements of this Section.

23 Rulemaking authority to implement Public Act 95-1045, if
24 any, is conditioned on the rules being adopted in accordance
25 with all provisions of the Illinois Administrative Procedure

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

4 (Source: P.A. 103-84, eff. 1-1-24; 103-91, eff. 1-1-24;
5 103-420, eff. 1-1-24; 103-445, eff. 1-1-24; 103-535, eff.
6 8-11-23; 103-551, eff. 8-11-23; 103-605, eff. 7-1-24; 103-718,
7 eff. 7-19-24; 103-751, eff. 8-2-24; 103-914, eff. 1-1-25;
8 103-918, eff. 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff.
9 6-9-25; 104-27, eff. 1-1-26; 104-42, eff. 8-1-25; 104-68, eff.
10 1-1-26; 104-73, eff. 1-1-26; 104-289, eff. 1-1-26; 104-324,
11 eff. 1-1-26; 104-379, eff. 1-1-26; 104-417, eff. 8-15-25;
12 104-446, eff. 6-1-26; revised 1-8-26.)

13 Section 55. The Illinois Insurance Code is amended by
14 adding Section 356z.86 as follows:

15 (215 ILCS 5/356z.86 new)

16 Sec. 356z.86. Coverage for heart disease screening test. A
17 group or individual plan of accident and health insurance or
18 managed care plan amended, delivered, issued, or renewed on or
19 after January 1, 2027 shall provide coverage for a heart
20 disease screening test according to the following schedule:

21 (1) For individuals aged 20 through 39 years: one
22 screening every 6 years.

23 (2) For individuals aged 40 years and older: one
24 screening every 2 years.

1 Section 60. The Health Maintenance Organization Act is
2 amended by changing Section 5-3 as follows:

3 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

4 Sec. 5-3. Illinois Insurance Code provisions.

5 (a) Health Maintenance Organizations shall be subject to
6 the provisions of Sections 133, 134, 136, 137, 139, 140,
7 141.1, 141.2, 141.3, 143, 143.31, 143c, 147, 148, 149, 151,
8 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a,
9 155.49, 352c, 355.2, 355.3, 355.6, 355.7, 355b, 355c, 356f,
10 356g, 356g.5-1, 356m, 356q, 356u.10, 356v, 356w, 356x, 356z.2,
11 356z.3a, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9,
12 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17,
13 356z.18, 356z.19, 356z.20, 356z.21, 356z.22, 356z.23, 356z.24,
14 356z.25, 356z.26, 356z.28, 356z.29, 356z.30, 356z.31, 356z.32,
15 356z.33, 356z.34, 356z.35, 356z.36, 356z.37, 356z.38, 356z.39,
16 356z.40, 356z.40a, 356z.41, 356z.44, 356z.45, 356z.46,
17 356z.47, 356z.48, 356z.49, 356z.50, 356z.51, 356z.53, 356z.54,
18 356z.55, 356z.56, 356z.57, 356z.58, 356z.59, 356z.60, 356z.61,
19 356z.62, 356z.63, 356z.64, 356z.65, 356z.66, 356z.67, 356z.68,
20 356z.69, 356z.70, 356z.71, 356z.72, 356z.73, 356z.74, 356z.75,
21 356z.76, 356z.77, 356z.78, 356z.79, 356z.80, 356z.81, 356z.82,
22 356z.83, 356z.84, 356z.85, 364, 364.01, 364.3, 367.2, 367.2-5,
23 367i, 368a, 368b, 368c, 368d, 368e, 370a, 370c, 370c.1, 401,
24 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1,

1 paragraph (c) of subsection (2) of Section 367, and Articles
2 IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and
3 XXXIIB of the Illinois Insurance Code.Health Maintenance
4 Organizations shall be subject to the provisions of the Catch
5 Heart Disease Early Act.

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

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

12 (2) a corporation organized under the laws of this
13 State; or

14 (3) a corporation organized under the laws of another
15 state, 30% or more of the enrollees of which are residents
16 of this State, except a corporation subject to
17 substantially the same requirements in its state of
18 organization as is a "domestic company" under Article VIII
19 1/2 of the Illinois Insurance Code.

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

23 (1) the Director shall give primary consideration to
24 the continuation of benefits to enrollees and the
25 financial conditions of the acquired Health Maintenance
26 Organization after the merger, consolidation, or other

1 acquisition of control takes effect;

2 (2) (i) the criteria specified in subsection (1) (b) of
3 Section 131.8 of the Illinois Insurance Code shall not
4 apply and (ii) the Director, in making his determination
5 with respect to the merger, consolidation, or other
6 acquisition of control, need not take into account the
7 effect on competition of the merger, consolidation, or
8 other acquisition of control;

9 (3) the Director shall have the power to require the
10 following information:

11 (A) certification by an independent actuary of the
12 adequacy of the reserves of the Health Maintenance
13 Organization sought to be acquired;

14 (B) pro forma financial statements reflecting the
15 combined balance sheets of the acquiring company and
16 the Health Maintenance Organization sought to be
17 acquired as of the end of the preceding year and as of
18 a date 90 days prior to the acquisition, as well as pro
19 forma financial statements reflecting projected
20 combined operation for a period of 2 years;

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

25 (D) such other information as the Director shall
26 require.

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

7 (e) In considering any management contract or service
8 agreement subject to Section 141.1 of the Illinois Insurance
9 Code, the Director (i) shall, in addition to the criteria
10 specified in Section 141.2 of the Illinois Insurance Code,
11 take into account the effect of the management contract or
12 service agreement on the continuation of benefits to enrollees
13 and the financial condition of the health maintenance
14 organization to be managed or serviced, and (ii) need not take
15 into account the effect of the management contract or service
16 agreement on competition.

17 (f) Except for small employer groups as defined in the
18 Small Employer Rating, Renewability and Portability Health
19 Insurance Act and except for medicare supplement policies as
20 defined in Section 363 of the Illinois Insurance Code, a
21 Health Maintenance Organization may by contract agree with a
22 group or other enrollment unit to effect refunds or charge
23 additional premiums under the following terms and conditions:

24 (i) the amount of, and other terms and conditions with
25 respect to, the refund or additional premium are set forth
26 in the group or enrollment unit contract agreed in advance

1 of the period for which a refund is to be paid or
2 additional premium is to be charged (which period shall
3 not be less than one year); and

4 (ii) the amount of the refund or additional premium
5 shall not exceed 20% of the Health Maintenance
6 Organization's profitable or unprofitable experience with
7 respect to the group or other enrollment unit for the
8 period (and, for purposes of a refund or additional
9 premium, the profitable or unprofitable experience shall
10 be calculated taking into account a pro rata share of the
11 Health Maintenance Organization's administrative and
12 marketing expenses, but shall not include any refund to be
13 made or additional premium to be paid pursuant to this
14 subsection (f)). The Health Maintenance Organization and
15 the group or enrollment unit may agree that the profitable
16 or unprofitable experience may be calculated taking into
17 account the refund period and the immediately preceding 2
18 plan years.

19 The Health Maintenance Organization shall include a
20 statement in the evidence of coverage issued to each enrollee
21 describing the possibility of a refund or additional premium,
22 and upon request of any group or enrollment unit, provide to
23 the group or enrollment unit a description of the method used
24 to calculate (1) the Health Maintenance Organization's
25 profitable experience with respect to the group or enrollment
26 unit and the resulting refund to the group or enrollment unit

1 or (2) the Health Maintenance Organization's unprofitable
2 experience with respect to the group or enrollment unit and
3 the resulting additional premium to be paid by the group or
4 enrollment unit.

5 In no event shall the Illinois Health Maintenance
6 Organization Guaranty Association be liable to pay any
7 contractual obligation of an insolvent organization to pay any
8 refund authorized under this Section.

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

15 (Source: P.A. 103-84, eff. 1-1-24; 103-91, eff. 1-1-24;
16 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-420, eff.
17 1-1-24; 103-426, eff. 8-4-23; 103-445, eff. 1-1-24; 103-551,
18 eff. 8-11-23; 103-605, eff. 7-1-24; 103-618, eff. 1-1-25;
19 103-649, eff. 1-1-25; 103-656, eff. 1-1-25; 103-700, eff.
20 1-1-25; 103-718, eff. 7-19-24; 103-751, eff. 8-2-24; 103-753,
21 eff. 8-2-24; 103-758, eff. 1-1-25; 103-777, eff. 8-2-24;
22 103-808, eff. 1-1-26; 103-914, eff. 1-1-25; 103-918, eff.
23 1-1-25; 103-1024, eff. 1-1-25; 104-1, eff. 6-9-25; 104-28,
24 eff. 1-1-26; 104-42, eff. 8-1-25; 104-68, eff. 1-1-26; 104-73,
25 eff. 1-1-26; 104-98, eff. 1-1-26; 104-289, eff. 1-1-26;
26 104-324, eff. 1-1-26; 104-334, eff. 8-15-25; 104-379, eff.

1 1-1-26; 104-417, eff. 8-15-25; revised 11-21-25.)

2 Section 65. The Illinois Public Aid Code is amended by
3 changing Section 5-5 as follows:

4 (305 ILCS 5/5-5)

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

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

1 of remedial care recognized under the laws of this State. The
2 term "any other type of remedial care" shall include nursing
3 care and nursing home service for persons who rely on
4 treatment by spiritual means alone through prayer for healing.

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

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

17 Notwithstanding any other provision of this Section, all
18 tobacco cessation medications approved by the United States
19 Food and Drug Administration and all individual and group
20 tobacco cessation counseling services and telephone-based
21 counseling services and tobacco cessation medications provided
22 through the Illinois Tobacco Quitline shall be covered under
23 the medical assistance program for persons who are otherwise
24 eligible for assistance under this Article. The Department
25 shall comply with all federal requirements necessary to obtain
26 federal financial participation, as specified in 42 CFR

1 433.15(b)(7), for telephone-based counseling services provided
2 through the Illinois Tobacco Quitline, including, but not
3 limited to: (i) entering into a memorandum of understanding or
4 interagency agreement with the Department of Public Health, as
5 administrator of the Illinois Tobacco Quitline; and (ii)
6 developing a cost allocation plan for Medicaid-allowable
7 Illinois Tobacco Quitline services in accordance with 45 CFR
8 95.507. The Department shall submit the memorandum of
9 understanding or interagency agreement, the cost allocation
10 plan, and all other necessary documentation to the Centers for
11 Medicare and Medicaid Services for review and approval.
12 Coverage under this paragraph shall be contingent upon federal
13 approval.

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

21 Upon receipt of federal approval of an amendment to the
22 Illinois Title XIX State Plan for this purpose, the Department
23 shall authorize the Chicago Public Schools (CPS) to procure a
24 vendor or vendors to manufacture eyeglasses for individuals
25 enrolled in a school within the CPS system. CPS shall ensure
26 that its vendor or vendors are enrolled as providers in the

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

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

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

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

24 On and after July 1, 2018, the Department of Healthcare
25 and Family Services shall provide dental services to any adult
26 who is otherwise eligible for assistance under the medical

1 assistance program. As used in this paragraph, "dental
2 services" means diagnostic, preventative, restorative, or
3 corrective procedures, including procedures and services for
4 the prevention and treatment of periodontal disease and dental
5 caries disease, provided by an individual who is licensed to
6 practice dentistry or dental surgery or who is under the
7 supervision of a dentist in the practice of his or her
8 profession.

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

19 Subject to federal approval, on and after January 1, 2025,
20 the rates paid for sedation evaluation and the provision of
21 deep sedation and intravenous sedation for the purpose of
22 dental services shall be increased by 33% above the rates in
23 effect on December 31, 2024. The rates paid for nitrous oxide
24 sedation shall not be impacted by this paragraph and shall
25 remain the same as the rates in effect on December 31, 2024.

26 Notwithstanding any other provision of this Code and

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

13 Subject to appropriation and to federal approval, the
14 Department shall file administrative rules updating the
15 Handicapping Labio-Lingual Deviation orthodontic scoring tool
16 by January 1, 2025, or as soon as practicable.

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

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

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

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

24 The Illinois Department shall authorize the provision of,
25 and shall authorize payment for, screening by low-dose
26 mammography for the presence of occult breast cancer for

1 individuals 35 years of age or older who are eligible for
2 medical assistance under this Article, as follows:

3 (A) A baseline mammogram for individuals 35 to 39
4 years of age.

5 (B) An annual mammogram for individuals 40 years of
6 age or older.

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

13 (D) A comprehensive ultrasound screening and MRI of an
14 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.

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

21 (F) A diagnostic mammogram when medically necessary,
22 as determined by a physician licensed to practice medicine
23 in all its branches, advanced practice registered nurse,
24 or physician assistant.

25 (G) Molecular breast imaging (MBI) and MRI of an
26 entire breast or breasts if a mammogram demonstrates

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

5 The Department shall not impose a deductible, coinsurance,
6 copayment, or any other cost-sharing requirement on the
7 coverage provided under this paragraph; 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 All screenings shall include a physical breast exam,
14 instruction on self-examination and information regarding the
15 frequency of self-examination and its value as a preventative
16 tool.

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 an average radiation exposure delivery of
3 less than one rad per breast for 2 views of an average size
4 breast. The term also includes digital mammography and
5 includes breast 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 paragraph, 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 paragraph.

26 On and after January 1, 2016, the Department shall ensure

1 that all networks of care for adult clients of the Department
2 include access to at least one breast imaging Center of
3 Imaging Excellence as certified by the American College of
4 Radiology.

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

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

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

22 The Department shall convene an expert panel, including
23 representatives of hospitals, free-standing breast cancer
24 treatment centers, breast cancer quality organizations, and
25 doctors, including radiologists that are trained in all forms
26 of FDA-approved breast imaging technologies, breast surgeons,

1 reconstructive breast surgeons, oncologists, and primary care
2 providers to establish quality standards for breast cancer
3 treatment.

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

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

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

26 The Department shall devise a means of case-managing or

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

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

22 The Department shall provide coverage and reimbursement
23 for a human papillomavirus (HPV) vaccine that is approved for
24 marketing by the federal Food and Drug Administration for all
25 persons between the ages of 9 and 45. Subject to federal
26 approval, the Department shall provide coverage and

1 reimbursement for a human papillomavirus (HPV) vaccine for
2 persons of the age of 46 and above who have been diagnosed with
3 cervical dysplasia with a high risk of recurrence or
4 progression. The Department shall disallow any
5 preauthorization requirements for the administration of the
6 human papillomavirus (HPV) vaccine.

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

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

26 All medical providers providing medical assistance to

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

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

15 Neither the Department of Healthcare and Family Services
16 nor the Department of Human Services shall sanction the
17 recipient solely on the basis of the recipient's substance
18 abuse.

19 The Illinois Department shall establish such regulations
20 governing the dispensing of health services under this Article
21 as it shall deem appropriate. The Department should seek the
22 advice of formal professional advisory committees appointed by
23 the Director of the Illinois Department for the purpose of
24 providing regular advice on policy and administrative matters,
25 information dissemination and educational activities for
26 medical and health care providers, and consistency in

1 procedures to the Illinois Department.

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

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

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

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

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

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

17 Nothing in this Section shall limit the free choice of
18 practitioners, hospitals, and other providers of medical
19 services by clients. In order to ensure patient freedom of
20 choice, the Illinois Department shall immediately promulgate
21 all rules and take all other necessary actions so that
22 provided services may be accessed from therapeutically
23 certified optometrists to the full extent of the Illinois
24 Optometric Practice Act of 1987 without discriminating between
25 service providers.

26 The Department shall apply for a waiver from the United

1 States Health Care Financing Administration to allow for the
2 implementation of Partnerships under this Section.

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

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

18 Notwithstanding any other law to the contrary, the
19 Illinois Department shall, within 365 days after July 22, 2013
20 (the effective date of Public Act 98-104), establish
21 procedures to permit skilled care facilities licensed under
22 the Nursing Home Care Act to submit monthly billing claims for
23 reimbursement purposes. Following development of these
24 procedures, the Department shall, by July 1, 2016, test the
25 viability of the new system and implement any necessary
26 operational or structural changes to its information

1 technology platforms in order to allow for the direct
2 acceptance and payment of nursing home claims.

3 Notwithstanding any other law to the contrary, the
4 Illinois Department shall, within 365 days after August 15,
5 2014 (the effective date of Public Act 98-963), establish
6 procedures to permit ID/DD facilities licensed under the ID/DD
7 Community Care Act and MC/DD facilities licensed under the
8 MC/DD Act to submit monthly billing claims for reimbursement
9 purposes. Following development of these procedures, the
10 Department shall have an additional 365 days to test the
11 viability of the new system and to ensure that any necessary
12 operational or structural changes to its information
13 technology platforms are implemented.

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

23 The Illinois Department may require that all dispensers of
24 medical services desiring to participate in the medical
25 assistance program established under this Article disclose,
26 under such terms and conditions as the Illinois Department may

1 by rule establish, all inquiries from clients and attorneys
2 regarding medical bills paid by the Illinois Department, which
3 inquiries could indicate potential existence of claims or
4 liens for the Illinois Department.

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

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

17 Prior to enrollment and during the conditional enrollment
18 period in the medical assistance program, all vendors shall be
19 subject to enhanced oversight, screening, and review based on
20 the risk of fraud, waste, and abuse that is posed by the
21 category of risk of the vendor. The Illinois Department shall
22 establish the procedures for oversight, screening, and review,
23 which may include, but need not be limited to: criminal and
24 financial background checks; fingerprinting; license,
25 certification, and authorization verifications; unscheduled or
26 unannounced site visits; database checks; prepayment audit

1 reviews; audits; payment caps; payment suspensions; and other
2 screening as required by federal or State law.

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

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

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

25 (2) In the case of errors attributable to the Illinois
26 Department or any of its claims processing intermediaries

1 which result in an inability to receive, process, or
2 adjudicate a claim, the 180-day period shall not begin
3 until the provider has been notified of the error.

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

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

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

17 In the case of long term care facilities, within 120
18 calendar days of receipt by the facility of required
19 prescreening information, new admissions with associated
20 admission documents shall be submitted through the Medical
21 Electronic Data Interchange (MEDI) or the Recipient
22 Eligibility Verification (REV) System or shall be submitted
23 directly to the Department of Human Services using required
24 admission forms. Effective September 1, 2014, admission
25 documents, including all prescreening information, must be
26 submitted through MEDI or REV. Confirmation numbers assigned

1 to an accepted transaction shall be retained by a facility to
2 verify timely submittal. Once an admission transaction has
3 been completed, all resubmitted claims following prior
4 rejection are subject to receipt no later than 180 days after
5 the admission transaction has been completed.

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

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

24 The Illinois Department shall enter into agreements with
25 State agencies and departments, and is authorized to enter
26 into agreements with federal agencies and departments, under

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

15 Beginning in fiscal year 2013, the Illinois Department
16 shall set forth a request for information to identify the
17 benefits of a pre-payment, post-adjudication, and post-edit
18 claims system with the goals of streamlining claims processing
19 and provider reimbursement, reducing the number of pending or
20 rejected claims, and helping to ensure a more transparent
21 adjudication process through the utilization of: (i) provider
22 data verification and provider screening technology; and (ii)
23 clinical code editing; and (iii) pre-pay, pre-adjudicated, or
24 post-adjudicated predictive modeling with an integrated case
25 management system with link analysis. Such a request for
26 information shall not be considered as a request for proposal

1 or as an obligation on the part of the Illinois Department to
2 take any action or acquire any products or services.

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

24 The Department shall require, by rule, all providers of
25 durable medical equipment to be accredited by an accreditation
26 organization approved by the federal Centers for Medicare and

1 Medicaid Services and recognized by the Department in order to
2 bill the Department for providing durable medical equipment to
3 recipients. No later than 15 months after the effective date
4 of the rule adopted pursuant to this paragraph, all providers
5 must meet the accreditation requirement.

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

1 recipient or enrollee is not already in receipt of the same or
2 similar equipment from another service provider, and that the
3 refurbished durable medical equipment equally meets the needs
4 of the recipient or enrollee. Nothing in this paragraph shall
5 be construed to limit recipient or enrollee choice to obtain
6 new durable medical equipment or place any additional prior
7 authorization conditions on enrollees of managed care
8 organizations.

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

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

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

21 The Illinois Department shall report annually to the
22 General Assembly, no later than the second Friday in April of
23 1979 and each year thereafter, in regard to:

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

26 (b) actual statistics and trends in the provision of

1 the various medical services by medical vendors;

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

4 (d) efforts at utilization review and control by the
5 Illinois Department.

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

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

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

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

17 Notwithstanding any other provision of this Code to the
18 contrary, on or after July 1, 2015, all FDA-approved forms of
19 medication assisted treatment prescribed for the treatment of
20 alcohol dependence or treatment of opioid dependence shall be
21 covered under both fee-for-service and managed care medical
22 assistance programs for persons who are otherwise eligible for
23 medical assistance under this Article and shall not be subject
24 to any (1) utilization control, other than those established
25 under the American Society of Addiction Medicine patient
26 placement criteria, (2) prior authorization mandate, (3)

1 lifetime restriction limit mandate, or (4) limitations on
2 dosage.

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

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

1 counseling to reduce the likelihood of HIV infection among
2 individuals who are not infected with HIV but who are at high
3 risk of HIV infection.

4 A federally qualified health center, as defined in Section
5 1905(1)(2)(B) of the federal Social Security Act, shall be
6 reimbursed by the Department in accordance with the federally
7 qualified health center's encounter rate for services provided
8 to medical assistance recipients that are performed by a
9 dental hygienist, as defined under the Illinois Dental
10 Practice Act, working under the general supervision of a
11 dentist and employed by a federally qualified health center.

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

19 Subject to approval by the federal Centers for Medicare
20 and Medicaid Services of a Title XIX State Plan amendment
21 electing the Program of All-Inclusive Care for the Elderly
22 (PACE) as a State Medicaid option, as provided for by Subtitle
23 I (commencing with Section 4801) of Title IV of the Balanced
24 Budget Act of 1997 (Public Law 105-33) and Part 460
25 (commencing with Section 460.2) of Subchapter E of Title 42 of
26 the Code of Federal Regulations, PACE program services shall

1 become a covered benefit of the medical assistance program,
2 subject to criteria established in accordance with all
3 applicable laws.

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

9 Notwithstanding any other provision of this Code, within
10 12 months after June 2, 2022 (the effective date of Public Act
11 102-1037) and subject to federal approval, acupuncture
12 services performed by an acupuncturist licensed under the
13 Acupuncture Practice Act who is acting within the scope of his
14 or her license shall be covered under the medical assistance
15 program. The Department shall apply for any federal waiver or
16 State Plan amendment, if required, to implement this
17 paragraph. The Department may adopt any rules, including
18 standards and criteria, necessary to implement this paragraph.

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

1 subject to appropriation and federal approval, also reimburse
2 hospitals for costs associated with all newborn screening
3 tests added on and after August 9, 2024 (the effective date of
4 Public Act 103-909) to the Newborn Metabolic Screening Act and
5 required to be performed under that Act at a rate not less than
6 the fee charged by the Department of Public Health. The
7 Department shall seek federal approval before the
8 implementation of the newborn screening test fees by the
9 Department of Public Health.

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

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

26 Subject to federal approval, for dates of services on and

1 after January 1, 2026, over-the-counter choline dietary
2 supplements for pregnant persons shall be covered under the
3 medical assistance program.

4 Notwithstanding any other provision of this Code, subject
5 to federal approval, heart disease screenings for individuals
6 otherwise eligible for medical assistance shall be covered
7 under the medical assistance program according to the
8 following schedule:

9 (1) For individuals aged 20 through 39 years: one
10 screening every 6 years.

11 (2) For individuals aged 40 years and older: one
12 screening every 2 years.

13 No eligible individual shall be charged any co-payment,
14 co-insurance, deductible, out-of-pocket fee, or other
15 cost-sharing amount or required to enter into any cost-sharing
16 agreement in order to access heart disease screenings covered
17 under this paragraph.

18 (Source: P.A. 103-102, Article 15, Section 15-5, eff. 1-1-24;
19 103-102, Article 95, Section 95-15, eff. 1-1-24; 103-123, eff.
20 1-1-24; 103-154, eff. 6-30-23; 103-368, eff. 1-1-24; 103-593,
21 Article 5, Section 5-5, eff. 6-7-24; 103-593, Article 90,
22 Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24; 103-808, eff.
23 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff. 8-9-24; 104-9,
24 eff. 6-16-25; 104-417, eff. 8-15-25.)

25 Section 95. No acceleration or delay. Where this Act makes

1 changes in a statute that is represented in this Act by text
2 that is not yet or no longer in effect (for example, a Section
3 represented by multiple versions), the use of that text does
4 not accelerate or delay the taking effect of (i) the changes
5 made by this Act or (ii) provisions derived from any other
6 Public Act.

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

1 INDEX

2 Statutes amended in order of appearance

3 New Act

4 5 ILCS 375/6.11

5 55 ILCS 5/5-1069.3

6 65 ILCS 5/10-4-2.3

7 105 ILCS 5/10-22.3f

8 215 ILCS 5/356z.86 new

9 215 ILCS 125/5-3 from Ch. 111 1/2, par. 1411.2

10 305 ILCS 5/5-5