AN ACT concerning health.

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

Section 1. This Act may be referred to as the Improving Health Care for Pregnant and Postpartum Individuals Act.

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.4a, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, and 356z.41 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 and Article XXXIIB of the Illinois Insurance Code. The Department of
Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 of the Illinois Insurance Code; all other requirements of this Section shall be enforced by the Department of Central Management Services.

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

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 100-1170, eff. 6-1-19; 101-13, eff. 6-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21.)

Section 10. The Department of Human Services Act is amended by adding Section 10-23 as follows:

(20 ILCS 1305/10-23 new)

Sec. 10-23. High-risk pregnant or postpartum individuals. The Department shall expand and update its maternal child health programs to serve pregnant and postpartum individuals determined to be high-risk using criteria established by a multi-agency working group. The services shall be provided by
registered nurses, licensed social workers, or other staff with behavioral health or medical training, as approved by the Department. The persons providing the services may collaborate with other providers, including, but not limited to, obstetricians, gynecologists, or pediatricians, when providing services to a patient.

Section 15. The Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois is amended by renumbering and changing Section 2310-223, as added by Public Act 101-390, and by adding Section 2310-470 as follows:

(20 ILCS 2310/2310-222)

Sec. 2310-222. Obstetric hemorrhage and hypertension training.

(a) As used in this Section:

"Birthing facility" means (1) a hospital, as defined in the Hospital Licensing Act, with more than one licensed obstetric bed or a neonatal intensive care unit; (2) a hospital operated by a State university; or (3) a birth center, as defined in the Alternative Health Care Delivery Act.

"Postpartum" means the 12-month period after a person has delivered a baby.

(b) The Department shall ensure that all birthing
facilities have a written policy and conduct continuing education yearly for providers and staff of obstetric medicine and of the emergency department and other staff that may care for pregnant or postpartum women. The written policy and continuing education shall include yearly educational modules regarding management of severe maternal hypertension and obstetric hemorrhage and other leading causes of maternal mortality for units that care for pregnant or postpartum women. Birthing facilities must demonstrate compliance with these written policy, education, and training requirements.

(c) The Department shall collaborate with the Illinois Perinatal Quality Collaborative or its successor organization to develop an initiative to improve birth equity and reduce peripartum racial and ethnic disparities. The Department shall ensure that the initiative includes the development of best practices for implicit bias training and education in cultural competency to be used by birthing facilities in interactions between patients and providers. In developing the initiative, the Illinois Perinatal Quality Collaborative or its successor organization shall consider existing programs, such as the Alliance for Innovation on Maternal Health and the California Maternal Quality Collaborative's pilot work on improving birth equity. The Department shall support the initiation of a statewide perinatal quality improvement initiative in collaboration with birthing facilities to implement strategies to reduce peripartum racial and ethnic disparities and to
address implicit bias in the health care system.

(d) In order to better facilitate continuity of care, the Department, in consultation with the Illinois Perinatal Quality Collaborative Maternal Mortality Review Committee, shall make available to all birthing facilities best practices for timely identification and assessment of all pregnant and postpartum women for common pregnancy or postpartum complications in the emergency department and for care provided by the birthing facility throughout the pregnancy and postpartum period. The best practices shall include the appropriate and timely consultation of an obstetric or other relevant provider to provide input on management and follow-up, such as offering coordination of a post-delivery early postpartum visit or other services that may be appropriate and available. Birthing facilities shall incorporate these best practices into the written policy required under subsection (b). Birthing facilities may use telemedicine for the consultation.

(e) The Department may adopt rules for the purpose of implementing this Section.

(Source: P.A. 101-390, eff. 1-1-20; revised 10-7-19.)

(20 ILCS 2310/2310-470 new)

Sec. 2310-470. High Risk Infant Follow-up. The Department, in collaboration with the Department of Human Services, the Department of Healthcare and Family Services, and other key
providers of maternal child health services, shall revise or add to the rules of the Maternal and Child Health Services Code (77 Ill. Adm. Code 630) that govern the High Risk Infant Follow-up, using current scientific and national and State outcomes data, to revise or expand existing services to improve both maternal and infant outcomes overall and to reduce racial disparities in outcomes and services provided. The rules shall be revised or adopted on or before June 1, 2024.

Section 20. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, and 356z.41 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, and 370c of the Illinois
Insurance Code. The Department of Insurance shall enforce the requirements of this Section. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

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

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21.)

Section 25. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a
self-insurer for purposes of providing health insurance
coverage for its employees, the coverage shall include
coverage for the post-mastectomy care benefits required to be
covered by a policy of accident and health insurance under
Section 356t and the coverage required under Sections 356g,
356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9,
356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22,
356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33,
The coverage shall comply with Sections 155.22a, 355b,
356z.19, and 370c of the Illinois Insurance Code. The
Department of Insurance shall enforce the requirements of this
Section. The requirement that health benefits be covered as
provided in this is an exclusive power and function of the
State and is a denial and limitation under Article VII,
Section 6, subsection (h) of the Illinois Constitution. A home
rule municipality to which this Section applies must comply
with every provision of this Section.

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

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17;
100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff.
Section 30. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30a, 356z.32, 356z.33, 356z.36, 356z.40, and 356z.41 of the Illinois Insurance Code. Insurance policies shall comply with Section 356z.19 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

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

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-393, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21.)

Section 35. The Illinois Insurance Code is amended by adding Sections 356z.4b and 356z.40 as follows:

(215 ILCS 5/356z.4b new)

Sec. 356z.4b. Billing for long-acting reversible contraceptives.

(a) In this Section, "long-acting reversible contraceptive device" means any intrauterine device or contraceptive implant.

(b) Any individual or group policy of accident and health insurance or qualified health plan that is offered through the health insurance marketplace that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall allow hospitals separate reimbursement for a long-acting reversible contraceptive device provided immediately postpartum in the inpatient hospital setting before hospital discharge. The payment shall be made in addition to a bundled or Diagnostic Related Group reimbursement for labor and delivery.
Sec. 356z.40. Pregnancy and postpartum coverage.

(a) An individual or group policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall provide coverage for pregnancy and newborn care in accordance with 42 U.S.C. 18022(b) regarding essential health benefits.

(b) Benefits under this Section shall be as follows:

(1) An individual who has been identified as experiencing a high-risk pregnancy by the individual's treating provider shall have access to clinically appropriate case management programs. As used in this subsection, "case management" means a mechanism to coordinate and assure continuity of services, including, but not limited to, health services, social services, and educational services necessary for the individual. "Case management" involves individualized assessment of needs, planning of services, referral, monitoring, and advocacy to assist an individual in gaining access to appropriate services and closure when services are no longer required. "Case management" is an active and collaborative process involving a single qualified case manager, the individual, the individual's family, the providers, and the community. This includes close coordination and involvement with all
service providers in the management plan for that individual or family, including assuring that the individual receives the services. As used in this subsection, "high-risk pregnancy" means a pregnancy in which the pregnant or postpartum individual or baby is at an increased risk for poor health or complications during pregnancy or childbirth, including, but not limited to, hypertension disorders, gestational diabetes, and hemorrhage.

(2) An individual shall have access to medically necessary treatment of a mental, emotional, nervous, or substance use disorder or condition consistent with the requirements set forth in this Section and in Sections 370c and 370c.1 of this Code.

(3) The benefits provided for inpatient and outpatient services for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications shall be provided if determined to be medically necessary, consistent with the requirements of Sections 370c and 370c.1 of this Code. The facility or provider shall notify the insurer of both the admission and the initial treatment plan within 48 hours after admission or initiation of treatment. Nothing in this paragraph shall prevent an insurer from applying concurrent and post-service utilization review of health care services, including review of medical necessity, case
management, experimental and investigational treatments, managed care provisions, and other terms and conditions of the insurance policy.

(4) The benefits for the first 48 hours of initiation of services for an inpatient admission, detoxification or withdrawal management program, or partial hospitalization admission for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications shall be provided without post-service or concurrent review of medical necessity, as the medical necessity for the first 48 hours of such services shall be determined solely by the covered pregnant or postpartum individual's provider. Nothing in this paragraph shall prevent an insurer from applying concurrent and post-service utilization review, including the review of medical necessity, case management, experimental and investigational treatments, managed care provisions, and other terms and conditions of the insurance policy, of any inpatient admission, detoxification or withdrawal management program admission, or partial hospitalization admission services for the treatment of a mental, emotional, nervous, or substance use disorder or condition related to pregnancy or postpartum complications received 48 hours after the initiation of such services. If an insurer determines that the services are no longer medically necessary, then the
covered person shall have the right to external review pursuant to the requirements of the Health Carrier External Review Act.

(5) If an insurer determines that continued inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment in a facility is no longer medically necessary, the insurer shall, within 24 hours, provide written notice to the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider of its decision and the right to file an expedited internal appeal of the determination. The insurer shall review and make a determination with respect to the internal appeal within 24 hours and communicate such determination to the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider. If the determination is to uphold the denial, the covered pregnant or postpartum individual and the covered pregnant or postpartum individual's provider have the right to file an expedited external appeal. An independent utilization review organization shall make a determination within 72 hours. If the insurer's determination is upheld and it is determined that continued inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment is
not medically necessary, the insurer shall remain responsible for providing benefits for the inpatient care, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment through the day following the date the determination is made, and the covered pregnant or postpartum individual shall only be responsible for any applicable copayment, deductible, and coinsurance for the stay through that date as applicable under the policy. The covered pregnant or postpartum individual shall not be discharged or released from the inpatient facility, detoxification or withdrawal management, partial hospitalization, intensive outpatient treatment, or outpatient treatment until all internal appeals and independent utilization review organization appeals are exhausted. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act.

(6) Except as otherwise stated in this subsection (b), the benefits and cost-sharing shall be provided to the same extent as for any other medical condition covered under the policy.

(7) The benefits required by paragraphs (2) and (6) of this subsection (b) are to be provided to all covered pregnant or postpartum individuals with a diagnosis of a mental, emotional, nervous, or substance use disorder or condition. The presence of additional related or unrelated
diagnoses shall not be a basis to reduce or deny the
benefits required by this subsection (b).

Section 40. The Health Maintenance Organization Act is
amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)
Sec. 5-3. Insurance Code provisions.
(a) Health Maintenance Organizations shall be subject to
the provisions of Sections 133, 134, 136, 137, 139, 140,
141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,
154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2,
355.3, 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2,
356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10,
356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18,
356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30,
356z.30a, 356z.32, 356z.33, 356z.35, 356z.36, 356z.40,
356z.41, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c,
368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408,
408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection
(2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2,
XIII, XIII 1/2, XXV, XXVI, and XXXIIIB of the Illinois
Insurance Code.
(b) For purposes of the Illinois Insurance Code, except
for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
Health Maintenance Organizations in the following categories
are deemed to be "domestic companies":

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.
(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1026, eff. 8-22-18; 100-1057, eff. 1-1-19; 101-13, eff. 6-12-19; 101-81, eff. 7-12-19; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-393, eff. 1-1-20; 101-452, eff. 1-1-20; 101-461, eff. 1-1-20; 101-625, eff. 1-1-21.)

Section 45. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 155.22a, 155.37, 354, 355.2, 355.3, 355b, 356g, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.4a, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29,
Section 50. The Illinois Public Aid Code is amended by changing Sections 5-2, 5-5, and 5-5.24 and by adding Section 5-18.10 as follows:

(305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

Sec. 5-2. Classes of persons eligible. Medical assistance under this Article shall be available to any of the following classes of persons in respect to whom a plan for coverage has been submitted to the Governor by the Illinois Department and approved by him. If changes made in this Section 5-2 require
federal approval, they shall not take effect until such approval has been received:

1. Recipients of basic maintenance grants under Articles III and IV.

2. Beginning January 1, 2014, persons otherwise eligible for basic maintenance under Article III, excluding any eligibility requirements that are inconsistent with any federal law or federal regulation, as interpreted by the U.S. Department of Health and Human Services, but who fail to qualify thereunder on the basis of need, and who have insufficient income and resources to meet the costs of necessary medical care, including but not limited to the following:

   (a) All persons otherwise eligible for basic maintenance under Article III but who fail to qualify under that Article on the basis of need and who meet either of the following requirements:

       (i) their income, as determined by the Illinois Department in accordance with any federal requirements, is equal to or less than 100% of the federal poverty level; or

       (ii) their income, after the deduction of costs incurred for medical care and for other types of remedial care, is equal to or less than 100% of the federal poverty level.

   (b) (Blank).
3. (Blank).

4. Persons not eligible under any of the preceding paragraphs who fall sick, are injured, or die, not having sufficient money, property or other resources to meet the costs of necessary medical care or funeral and burial expenses.

5. (a) Beginning January 1, 2020, individuals women during pregnancy and during the 12-month period beginning on the last day of the pregnancy, together with their infants, whose income is at or below 200% of the federal poverty level. Until September 30, 2019, or sooner if the maintenance of effort requirements under the Patient Protection and Affordable Care Act are eliminated or may be waived before then, individuals women during pregnancy and during the 12-month period beginning on the last day of the pregnancy, whose countable monthly income, after the deduction of costs incurred for medical care and for other types of remedial care as specified in administrative rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1, 2013 as set forth in administrative rule.

(b) The plan for coverage shall provide ambulatory prenatal care to pregnant individuals women during a presumptive eligibility period and establish an income eligibility standard that is equal to 200% of the federal poverty level, provided that costs incurred for medical
(c) The Illinois Department may conduct a demonstration in at least one county that will provide medical assistance to pregnant individuals together with their infants and children up to one year of age, where the income eligibility standard is set up to 185% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget. The Illinois Department shall seek and obtain necessary authorization provided under federal law to implement such a demonstration. Such demonstration may establish resource standards that are not more restrictive than those established under Article IV of this Code.

6. (a) Children younger than age 19 when countable income is at or below 133% of the federal poverty level. Until September 30, 2019, or sooner if the maintenance of effort requirements under the Patient Protection and Affordable Care Act are eliminated or may be waived before then, children younger than age 19 whose countable monthly income, after the deduction of costs incurred for medical care and for other types of remedial care as specified in administrative rule, is equal to or less than the Medical Assistance-No Grant(C) (MANG(C)) Income Standard in effect on April 1, 2013 as set forth in administrative rule.

(b) Children and youth who are under temporary custody
or guardianship of the Department of Children and Family Services or who receive financial assistance in support of an adoption or guardianship placement from the Department of Children and Family Services.

7. (Blank).

8. As required under federal law, persons who are eligible for Transitional Medical Assistance as a result of an increase in earnings or child or spousal support received. The plan for coverage for this class of persons shall:

(a) extend the medical assistance coverage to the extent required by federal law; and

(b) offer persons who have initially received 6 months of the coverage provided in paragraph (a) above, the option of receiving an additional 6 months of coverage, subject to the following:

(i) such coverage shall be pursuant to provisions of the federal Social Security Act;

(ii) such coverage shall include all services covered under Illinois' State Medicaid Plan;

(iii) no premium shall be charged for such coverage; and

(iv) such coverage shall be suspended in the event of a person's failure without good cause to file in a timely fashion reports required for this coverage under the Social Security Act and
coverage shall be reinstated upon the filing of such reports if the person remains otherwise eligible.

9. Persons with acquired immunodeficiency syndrome (AIDS) or with AIDS-related conditions with respect to whom there has been a determination that but for home or community-based services such individuals would require the level of care provided in an inpatient hospital, skilled nursing facility or intermediate care facility the cost of which is reimbursed under this Article. Assistance shall be provided to such persons to the maximum extent permitted under Title XIX of the Federal Social Security Act.

10. Participants in the long-term care insurance partnership program established under the Illinois Long-Term Care Partnership Program Act who meet the qualifications for protection of resources described in Section 15 of that Act.

11. Persons with disabilities who are employed and eligible for Medicaid, pursuant to Section 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and, subject to federal approval, persons with a medically improved disability who are employed and eligible for Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of the Social Security Act, as provided by the Illinois Department by rule. In establishing eligibility standards
under this paragraph 11, the Department shall, subject to
federal approval:

(a) set the income eligibility standard at not
lower than 350% of the federal poverty level;
(b) exempt retirement accounts that the person
cannot access without penalty before the age of 59
1/2, and medical savings accounts established pursuant
to 26 U.S.C. 220;
(c) allow non-exempt assets up to $25,000 as to
those assets accumulated during periods of eligibility
under this paragraph 11; and
(d) continue to apply subparagraphs (b) and (c) in
determining the eligibility of the person under this
Article even if the person loses eligibility under
this paragraph 11.

12. Subject to federal approval, persons who are
eligible for medical assistance coverage under applicable
provisions of the federal Social Security Act and the
federal Breast and Cervical Cancer Prevention and
Treatment Act of 2000. Those eligible persons are defined
to include, but not be limited to, the following persons:

(1) persons who have been screened for breast or
cervical cancer under the U.S. Centers for Disease
Control and Prevention Breast and Cervical Cancer
Program established under Title XV of the federal
Public Health Service Service Act in accordance with
the requirements of Section 1504 of that Act as administered by the Illinois Department of Public Health; and

(2) persons whose screenings under the above program were funded in whole or in part by funds appropriated to the Illinois Department of Public Health for breast or cervical cancer screening.

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the coverage under this paragraph 12 within 30 days after July 3, 2001 (the effective date of Public Act 92-47) this amendatory Act of the 92nd General Assembly.

In addition to the persons who are eligible for medical assistance pursuant to subparagraphs (1) and (2) of this paragraph 12, and to be paid from funds appropriated to the Department for its medical programs, any uninsured person as defined by the Department in rules residing in Illinois who is younger than 65 years of age, who has been screened for breast and cervical cancer in accordance with standards and procedures adopted by the Department of Public Health for screening, and who is referred to the Department by the Department of Public Health as being in need of treatment for breast or cervical cancer is eligible for medical assistance.
benefits that are consistent with the benefits provided to those persons described in subparagraphs (1) and (2). Medical assistance coverage for the persons who are eligible under the preceding sentence is not dependent on federal approval, but federal moneys may be used to pay for services provided under that coverage upon federal approval.

13. Subject to appropriation and to federal approval, persons living with HIV/AIDS who are not otherwise eligible under this Article and who qualify for services covered under Section 5-5.04 as provided by the Illinois Department by rule.

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet the income guidelines of paragraph 2(a) of this Section and (i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical coverage under this paragraph 14 may be provided
for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Family Care Eligibility.

   (a) On and after July 1, 2012, a parent or other caretaker relative who is 19 years of age or older when countable income is at or below 133% of the federal poverty level. A person may not spend down to become eligible under this paragraph 15.

   (b) Eligibility shall be reviewed annually.

   (c) (Blank).

   (d) (Blank).

   (e) (Blank).

   (f) (Blank).

   (g) (Blank).

   (h) (Blank).

   (i) Following termination of an individual's coverage under this paragraph 15, the individual must be determined eligible before the person can be re-enrolled.
16. Subject to appropriation, uninsured persons who are not otherwise eligible under this Section who have been certified and referred by the Department of Public Health as having been screened and found to need diagnostic evaluation or treatment, or both diagnostic evaluation and treatment, for prostate or testicular cancer. For the purposes of this paragraph 16, uninsured persons are those who do not have creditable coverage, as defined under the Health Insurance Portability and Accountability Act, or have otherwise exhausted any insurance benefits they may have had, for prostate or testicular cancer diagnostic evaluation or treatment, or both diagnostic evaluation and treatment. To be eligible, a person must furnish a Social Security number. A person's assets are exempt from consideration in determining eligibility under this paragraph 16. Such persons shall be eligible for medical assistance under this paragraph 16 for so long as they need treatment for the cancer. A person shall be considered to need treatment if, in the opinion of the person's treating physician, the person requires therapy directed toward cure or palliation of prostate or testicular cancer, including recurrent metastatic cancer that is a known or presumed complication of prostate or testicular cancer and complications resulting from the treatment modalities themselves. Persons who require only routine monitoring services are not considered to need
treatment. "Medical assistance" under this paragraph 16 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. Notwithstanding any other provision of law, the Department (i) does not have a claim against the estate of a deceased recipient of services under this paragraph 16 and (ii) does not have a lien against any homestead property or other legal or equitable real property interest owned by a recipient of services under this paragraph 16.

17. Persons who, pursuant to a waiver approved by the Secretary of the U.S. Department of Health and Human Services, are eligible for medical assistance under Title XIX or XXI of the federal Social Security Act. Notwithstanding any other provision of this Code and consistent with the terms of the approved waiver, the Illinois Department, may by rule:

(a) Limit the geographic areas in which the waiver program operates.

(b) Determine the scope, quantity, duration, and quality, and the rate and method of reimbursement, of the medical services to be provided, which may differ from those for other classes of persons eligible for assistance under this Article.

(c) Restrict the persons' freedom in choice of providers.
18. Beginning January 1, 2014, persons aged 19 or older, but younger than 65, who are not otherwise eligible for medical assistance under this Section 5-2, who qualify for medical assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) and applicable federal regulations, and who have income at or below 133% of the federal poverty level plus 5% for the applicable family size as determined pursuant to 42 U.S.C. 1396a(e)(14) and applicable federal regulations. Persons eligible for medical assistance under this paragraph 18 shall receive coverage for the Health Benefits Service Package as that term is defined in subsection (m) of Section 5-1.1 of this Code. If Illinois' federal medical assistance percentage (FMAP) is reduced below 90% for persons eligible for medical assistance under this paragraph 18, eligibility under this paragraph 18 shall cease no later than the end of the third month following the month in which the reduction in FMAP takes effect.

19. Beginning January 1, 2014, as required under 42 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18 and younger than age 26 who are not otherwise eligible for medical assistance under paragraphs (1) through (17) of this Section who (i) were in foster care under the responsibility of the State on the date of attaining age 18 or on the date of attaining age 21 when a court has continued wardship for good cause as provided in Section
2-31 of the Juvenile Court Act of 1987 and (ii) received medical assistance under the Illinois Title XIX State Plan or waiver of such plan while in foster care.

20. Beginning January 1, 2018, persons who are foreign-born victims of human trafficking, torture, or other serious crimes as defined in Section 2-19 of this Code and their derivative family members if such persons: (i) reside in Illinois; (ii) are not eligible under any of the preceding paragraphs; (iii) meet the income guidelines of subparagraph (a) of paragraph 2; and (iv) meet the nonfinancial eligibility requirements of Sections 16-2, 16-3, and 16-5 of this Code. The Department may extend medical assistance for persons who are foreign-born victims of human trafficking, torture, or other serious crimes whose medical assistance would be terminated pursuant to subsection (b) of Section 16-5 if the Department determines that the person, during the year of initial eligibility (1) experienced a health crisis, (2) has been unable, after reasonable attempts, to obtain necessary information from a third party, or (3) has other extenuating circumstances that prevented the person from completing his or her application for status. The Department may adopt any rules necessary to implement the provisions of this paragraph.

21. Persons who are not otherwise eligible for medical assistance under this Section who may qualify for medical
assistance pursuant to 42 U.S.C. 1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the duration of any federal or State declared emergency due to COVID-19. Medical assistance to persons eligible for medical assistance solely pursuant to this paragraph 21 shall be limited to any in vitro diagnostic product (and the administration of such product) described in 42 U.S.C. 1396d(a)(3)(B) on or after March 18, 2020, any visit described in 42 U.S.C. 1396o(a)(2)(G), or any other medical assistance that may be federally authorized for this class of persons. The Department may also cover treatment of COVID-19 for this class of persons, or any similar category of uninsured individuals, to the extent authorized under a federally approved 1115 Waiver or other federal authority. Notwithstanding the provisions of Section 1-11 of this Code, due to the nature of the COVID-19 public health emergency, the Department may cover and provide the medical assistance described in this paragraph 21 to noncitizens who would otherwise meet the eligibility requirements for the class of persons described in this paragraph 21 for the duration of the State emergency period.

In implementing the provisions of Public Act 96-20, the Department is authorized to adopt only those rules necessary, including emergency rules. Nothing in Public Act 96-20 permits the Department to adopt rules or issue a decision that expands
eligibility for the FamilyCare Program to a person whose income exceeds 185% of the Federal Poverty Level as determined from time to time by the U.S. Department of Health and Human Services, unless the Department is provided with express statutory authority.

The eligibility of any such person for medical assistance under this Article is not affected by the payment of any grant under the Senior Citizens and Persons with Disabilities Property Tax Relief Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act.

The Department shall by rule establish the amounts of assets to be disregarded in determining eligibility for medical assistance, which shall at a minimum equal the amounts to be disregarded under the Federal Supplemental Security Income Program. The amount of assets of a single person to be disregarded shall not be less than $2,000, and the amount of assets of a married couple to be disregarded shall not be less than $3,000.

To the extent permitted under federal law, any person found guilty of a second violation of Article VIIIA shall be ineligible for medical assistance under this Article, as provided in Section 8A-8.

The eligibility of any person for medical assistance under this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person
in cases of serious illness, as long as neither the person nor
members of the person's family have actual control over the
donations or benefits or the disbursement of the donations or
benefits.

Notwithstanding any other provision of this Code, if the
United States Supreme Court holds Title II, Subtitle A,
Section 2001(a) of Public Law 111-148 to be unconstitutional,
or if a holding of Public Law 111-148 makes Medicaid
eligibility allowed under Section 2001(a) inoperable, the
State or a unit of local government shall be prohibited from
enrolling individuals in the Medical Assistance Program as the
result of federal approval of a State Medicaid waiver on or
after June 14, 2012 (the effective date of Public Act 97-687)
this amendatory Act of the 97th General Assembly, and any
individuals enrolled in the Medical Assistance Program
pursuant to eligibility permitted as a result of such a State
Medicaid waiver shall become immediately ineligible.

Notwithstanding any other provision of this Code, if an
Act of Congress that becomes a Public Law eliminates Section
2001(a) of Public Law 111-148, the State or a unit of local
government shall be prohibited from enrolling individuals in
the Medical Assistance Program as the result of federal
approval of a State Medicaid waiver on or after June 14, 2012
(the effective date of Public Act 97-687) this amendatory Act
of the 97th General Assembly, and any individuals enrolled in
the Medical Assistance Program pursuant to eligibility
permitted as a result of such a State Medicaid waiver shall become immediately ineligible.

Effective October 1, 2013, the determination of eligibility of persons who qualify under paragraphs 5, 6, 8, 15, 17, and 18 of this Section shall comply with the requirements of 42 U.S.C. 1396a(e)(14) and applicable federal regulations.

The Department of Healthcare and Family Services, the Department of Human Services, and the Illinois health insurance marketplace shall work cooperatively to assist persons who would otherwise lose health benefits as a result of changes made under Public Act 98-104 this amendatory Act of the 98th General Assembly to transition to other health insurance coverage.

(Source: P.A. 101-10, eff. 6-5-19; 101-649, eff. 7-7-20; revised 8-24-20.)

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

Sec. 5-5. Medical services. The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing home services; (5) physicians' services whether furnished in the
office, the patient's home, a hospital, a skilled nursing
home, or elsewhere; (6) medical care, or any other type of
remedial care furnished by licensed practitioners; (7) home
health care services; (8) private duty nursing service; (9)
clinic services; (10) dental services, including prevention
and treatment of periodontal disease and dental caries disease
for pregnant individuals, provided by an individual
licensed to practice dentistry or dental surgery; for purposes
of this item (10), "dental services" means diagnostic,
preventive, or corrective procedures provided by or under the
supervision of a dentist in the practice of his or her
profession; (11) physical therapy and related services; (12)
prescribed drugs, dentures, and prosthetic devices; and
eyeglasses prescribed by a physician skilled in the diseases
of the eye, or by an optometrist, whichever the person may
select; (13) other diagnostic, screening, preventive, and
rehabilitative services, including to ensure that the
individual's need for intervention or treatment of mental
disorders or substance use disorders or co-occurring mental
health and substance use disorders is determined using a
uniform screening, assessment, and evaluation process
inclusive of criteria, for children and adults; for purposes
of this item (13), a uniform screening, assessment, and
evaluation process refers to a process that includes an
appropriate evaluation and, as warranted, a referral;
"uniform" does not mean the use of a singular instrument,
tool, or process that all must utilize; (14) transportation and such other expenses as may be necessary; (15) medical treatment of sexual assault survivors, as defined in Section 1a of the Sexual Assault Survivors Emergency Treatment Act, for injuries sustained as a result of the sexual assault, including examinations and laboratory tests to discover evidence which may be used in criminal proceedings arising from the sexual assault; (16) the diagnosis and treatment of sickle cell anemia; and (17) any other medical care, and any other type of remedial care recognized under the laws of this State. The term "any other type of remedial care" shall include nursing care and nursing home service for persons who rely on treatment by spiritual means alone through prayer for healing.

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

Notwithstanding any other provision of this Code, reproductive health care that is otherwise legal in Illinois shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article.
Notwithstanding any other provision of this Code, the Illinois Department may not require, as a condition of payment for any laboratory test authorized under this Article, that a physician's handwritten signature appear on the laboratory test order form. The Illinois Department may, however, impose other appropriate requirements regarding laboratory test order documentation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) A screening MRI when medically necessary, as determined by a physician licensed to practice medicine in all of its branches.
(F) A diagnostic mammogram when medically necessary, as determined by a physician licensed to practice medicine in all its branches, advanced practice registered nurse, or physician assistant.

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

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

For purposes of this Section:

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

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

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

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

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

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

On and after January 1, 2012, providers participating in a quality improvement program approved by the Department shall be reimbursed for screening and diagnostic mammography at the same rate as the Medicare program's rates, including the increased reimbursement for digital mammography.

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

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

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

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

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

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

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

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

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

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

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

The Illinois Department, in cooperation with the
Departments of Human Services (as successor to the Department
of Alcoholism and Substance Abuse) and Public Health, through
a public awareness campaign, may provide information
concerning treatment for alcoholism and drug abuse and
addiction, prenatal health care, and other pertinent programs
directed at reducing the number of drug-affected infants born
to recipients of medical assistance.
Neither the Department of Healthcare and Family Services nor the Department of Human Services shall sanction the recipient solely on the basis of the recipient's her substance abuse.

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

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

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

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

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

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

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

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

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care
providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses for which payment is being made are actually being received by eligible recipients. Within 90 days after September 16, 1984 (the effective date of Public Act 83-1439), the Illinois Department shall establish a current list of acquisition costs for all prosthetic devices and any other items recognized as medical equipment and supplies reimbursable under this Article and shall update such list on a quarterly basis, except that
the acquisition costs of all prescription drugs shall be updated no less frequently than every 30 days as required by Section 5-5.12.

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after July 22, 2013 (the effective date of Public Act 98-104), establish procedures to permit skilled care facilities licensed under the Nursing Home Care Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall, by July 1, 2016, test the viability of the new system and implement any necessary operational or structural changes to its information technology platforms in order to allow for the direct acceptance and payment of nursing home claims.

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

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

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

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

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

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

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

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

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

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

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

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

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

In the case of long term care facilities, within 45
calendar days of receipt by the facility of required
prescreening information, new admissions with associated
admission documents shall be submitted through the Medical
Electronic Data Interchange (MEDI) or the Recipient
Eligibility Verification (REV) System or shall be submitted
directly to the Department of Human Services using required
admission forms. Effective September 1, 2014, admission
documents, including all prescreening information, must be
submitted through MEDI or REV. Confirmation numbers assigned
to an accepted transaction shall be retained by a facility to
verify timely submittal. Once an admission transaction has
been completed, all resubmitted claims following prior
rejection are subject to receipt no later than 180 days after
the admission transaction has been completed.

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

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

The Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Illinois Department shall develop, in cooperation with other State departments and agencies, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. At a minimum, and to the extent necessary to provide data sharing, the Illinois Department shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including, but not limited to: the Secretary of State; the Department of Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.
Beginning in fiscal year 2013, the Illinois Department shall set forth a request for information to identify the benefits of a pre-payment, post-adjudication, and post-edit claims system with the goals of streamlining claims processing and provider reimbursement, reducing the number of pending or rejected claims, and helping to ensure a more transparent adjudication process through the utilization of: (i) provider data verification and provider screening technology; and (ii) clinical code editing; and (iii) pre-pay, pre- or post-adjudicated predictive modeling with an integrated case management system with link analysis. Such a request for information shall not be considered as a request for proposal or as an obligation on the part of the Illinois Department to take any action or acquire any products or services.

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

Notwithstanding any provision of Section 5-5f to the contrary,
the Department may, by rule, exempt certain replacement
wheelchair parts from prior approval and, for wheelchairs,
wheelchair parts, wheelchair accessories, and related seating
and positioning items, determine the wholesale price by
methods other than actual acquisition costs.

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

In order to promote environmental responsibility, meet the
needs of recipients and enrollees, and achieve significant
cost savings, the Department, or a managed care organization
under contract with the Department, may provide recipients or
managed care enrollees who have a prescription or Certificate
of Medical Necessity access to refurbished durable medical
equipment under this Section (excluding prosthetic and
orthotic devices as defined in the Orthotics, Prosthetics, and
Pedorthics Practice Act and complex rehabilitation technology
products and associated services) through the State's assistive technology program's reutilization program, using staff with the Assistive Technology Professional (ATP) Certification if the refurbished durable medical equipment: (i) is available; (ii) is less expensive, including shipping costs, than new durable medical equipment of the same type; (iii) is able to withstand at least 3 years of use; (iv) is cleaned, disinfected, sterilized, and safe in accordance with federal Food and Drug Administration regulations and guidance governing the reprocessing of medical devices in health care settings; and (v) equally meets the needs of the recipient or enrollee. The reutilization program shall confirm that the recipient or enrollee is not already in receipt of same or similar equipment from another service provider, and that the refurbished durable medical equipment equally meets the needs of the recipient or enrollee. Nothing in this paragraph shall be construed to limit recipient or enrollee choice to obtain new durable medical equipment or place any additional prior authorization conditions on enrollees of managed care organizations.

The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department on Aging, to effect the following: (i) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (ii) the establishment and
development of non-institutional services in areas of the
State where they are not currently available or are
undeveloped; and (iii) notwithstanding any other provision of
law, subject to federal approval, on and after July 1, 2012, an
increase in the determination of need (DON) scores from 29 to
37 for applicants for institutional and home and
community-based long term care; if and only if federal
approval is not granted, the Department may, in conjunction
with other affected agencies, implement utilization controls
or changes in benefit packages to effectuate a similar savings
amount for this population; and (iv) no later than July 1,
2013, minimum level of care eligibility criteria for
institutional and home and community-based long term care; and
(v) no later than October 1, 2013, establish procedures to
permit long term care providers access to eligibility scores
for individuals with an admission date who are seeking or
receiving services from the long term care provider. In order
to select the minimum level of care eligibility criteria, the
Governor shall establish a workgroup that includes affected
agency representatives and stakeholders representing the
institutional and home and community-based long term care
interests. This Section shall not restrict the Department from
implementing lower level of care eligibility criteria for
community-based services in circumstances where federal
approval has been granted.

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

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

(a) actual statistics and trends in utilization of
medical services by public aid recipients;
(b) actual statistics and trends in the provision of
the various medical services by medical vendors;
(c) current rate structures and proposed changes in
those rate structures for the various medical vendors; and
(d) efforts at utilization review and control by the
Illinois Department.

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

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

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

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

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

On or after July 1, 2015, opioid antagonists prescribed for the treatment of an opioid overdose, including the medication product, administration devices, and any pharmacy fees related to the dispensing and administration of the opioid antagonist, shall be covered under the medical assistance program for persons who are otherwise eligible for medical assistance under this Article. As used in this Section, "opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

Upon federal approval, the Department shall provide
coverage and reimbursement for all drugs that are approved for
marketing by the federal Food and Drug Administration and that
are recommended by the federal Public Health Service or the
United States Centers for Disease Control and Prevention for
pre-exposure prophylaxis and related pre-exposure prophylaxis
services, including, but not limited to, HIV and sexually
transmitted infection screening, treatment for sexually
transmitted infections, medical monitoring, assorted labs, and
counseling to reduce the likelihood of HIV infection among
individuals who are not infected with HIV but who are at high
risk of HIV infection.

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

Within 90 days after the effective date of this amendatory
Act of the 102nd General Assembly, the Department shall seek
federal approval of a State Plan amendment to expand coverage
for family planning services that includes presumptive
eligibility to individuals whose income is at or below 208% of
the federal poverty level. Coverage under this Section shall
be effective beginning on July 1, 2022.
(Source: P.A. 100-201, eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18; 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff. 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18; 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff. 12-10-18; 101-209, eff. 8-5-19; 101-580, eff. 1-1-20; revised 9-18-19.)

(305 ILCS 5/5-5.24)

Sec. 5-5.24. Prenatal and perinatal care. The Department of Healthcare and Family Services may provide reimbursement under this Article for all prenatal and perinatal health care services that are provided for the purpose of preventing low-birthweight infants, reducing the need for neonatal intensive care hospital services, and promoting perinatal and maternal health. These services may include comprehensive risk assessments for pregnant individuals women, individuals women with infants, and infants, lactation counseling, nutrition counseling, childbirth support, psychosocial counseling, treatment and prevention of periodontal disease, language translation, nurse home visitation, and other support services that have been proven to improve birth and maternal health outcomes. The Department shall maximize the use of preventive prenatal and perinatal health care services consistent with federal statutes, rules, and regulations. The Department of Public Aid (now Department of Healthcare and Family Services) shall develop a plan for prenatal and perinatal preventive
health care and shall present the plan to the General Assembly by January 1, 2004. On or before January 1, 2006 and every 2 years thereafter, the Department shall report to the General Assembly concerning the effectiveness of prenatal and perinatal health care services reimbursed under this Section in preventing low-birthweight infants and reducing the need for neonatal intensive care hospital services. Each such report shall include an evaluation of how the ratio of expenditures for treating low-birthweight infants compared with the investment in promoting healthy births and infants in local community areas throughout Illinois relates to healthy infant development in those areas.

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

(Source: P.A. 97-689, eff. 6-14-12.)

(305 ILCS 5/5-18.10 new)

Sec. 5-18.10. Reimbursement for postpartum visits.

(a) In this Section:

"Certified lactation counselor" means a health care professional in lactation counseling who has demonstrated the necessary skills, knowledge, and attitudes to provide clinical breastfeeding counseling and management support to families
who are thinking about breastfeeding or who have questions or problems during the course of breastfeeding.

"Certified nurse midwife" means a person who exceeds the competencies for a midwife contained in the Essential Competencies for Midwifery Practice, published by the International Confederation of Midwives, and who qualifies as an advanced practice registered nurse.

"Community health worker" means a frontline public health worker who is a trusted member or has an unusually close understanding of the community served. This trusting relationship enables the community health worker to serve as a liaison, link, and intermediary between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

"International board-certified lactation consultant" means a health care professional who is certified by the International Board of Lactation Consultant Examiners and specializes in the clinical management of breastfeeding.

"Medical caseworker" means a health care professional who assists in the planning, coordination, monitoring, and evaluation of medical services for a patient with emphasis on quality of care, continuity of services, and affordability.

"Perinatal doula" means a trained provider of regular and voluntary physical, emotional, and educational support, but not medical or midwife care, to pregnant and birthing persons.
before, during, and after childbirth, otherwise known as the
perinatal period.

"Public health nurse" means a registered nurse who
promotes and protects the health of populations using
knowledge from nursing, social, and public health sciences.

(b) The Illinois Department shall establish a medical
assistance program to cover a universal postpartum visit
within the first 3 weeks after childbirth and a comprehensive
visit within 4 to 12 weeks postpartum for persons who are
otherwise eligible for medical assistance under this Article.
In addition, postpartum care services rendered by perinatal
doulas, certified lactation counselors, international
board-certified lactation consultants, public health nurses,
certified nurse midwives, community health workers, and
medical caseworkers shall be covered under the medical
assistance program.

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