



Rep. Nabeela Syed

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10300HB4180ham002

LRB103 34255 RPS 70899 a

1 AMENDMENT TO HOUSE BILL 4180

2 AMENDMENT NO. \_\_\_\_\_. Amend House Bill 4180, AS AMENDED,  
3 by replacing everything after the enacting clause with the  
4 following:

5 "Section 5. The Counties Code is amended by changing  
6 Section 5-1069 as follows:

7 (55 ILCS 5/5-1069) (from Ch. 34, par. 5-1069)

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

10 (a) The county board of any county may arrange to provide,  
11 for the benefit of employees of the county, group life,  
12 health, accident, hospital, and medical insurance, or any one  
13 or any combination of those types of insurance, or the county  
14 board may self-insure, for the benefit of its employees, all  
15 or a portion of the employees' group life, health, accident,  
16 hospital, and medical insurance, or any one or any combination

1 of those types of insurance, including a combination of  
2 self-insurance and other types of insurance authorized by this  
3 Section, provided that the county board complies with all  
4 other requirements of this Section. The insurance may include  
5 provision for employees who rely on treatment by prayer or  
6 spiritual means alone for healing in accordance with the  
7 tenets and practice of a well recognized religious  
8 denomination. The county board may provide for payment by the  
9 county of a portion or all of the premium or charge for the  
10 insurance with the employee paying the balance of the premium  
11 or charge, if any. If the county board undertakes a plan under  
12 which the county pays only a portion of the premium or charge,  
13 the county board shall provide for withholding and deducting  
14 from the compensation of those employees who consent to join  
15 the plan the balance of the premium or charge for the  
16 insurance.

17 (b) If the county board does not provide for  
18 self-insurance or for a plan under which the county pays a  
19 portion or all of the premium or charge for a group insurance  
20 plan, the county board may provide for withholding and  
21 deducting from the compensation of those employees who consent  
22 thereto the total premium or charge for any group life,  
23 health, accident, hospital, and medical insurance.

24 (c) The county board may exercise the powers granted in  
25 this Section only if it provides for self-insurance or, where  
26 it makes arrangements to provide group insurance through an

1 insurance carrier, if the kinds of group insurance are  
2 obtained from an insurance company authorized to do business  
3 in the State of Illinois. The county board may enact an  
4 ordinance prescribing the method of operation of the insurance  
5 program.

6 (d) If a county, including a home rule county, is a  
7 self-insurer for purposes of providing health insurance  
8 coverage for its employees, the insurance coverage shall  
9 include screening by low-dose mammography for all patients  
10 ~~women~~ 35 years of age or older for the presence of occult  
11 breast cancer unless the county elects to provide mammograms  
12 itself under Section 5-1069.1. The coverage shall be as  
13 follows:

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

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

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

24 (4) For a group policy of accident and health  
25 insurance that is amended, delivered, issued, or renewed  
26 on or after January 1, 2020 (the effective date of Public

1 ~~Act 101-580) this amendatory Act of the 101st General~~  
2 ~~Assembly,~~ a comprehensive ultrasound screening of an  
3 entire breast or breasts if a mammogram demonstrates  
4 heterogeneous or dense breast tissue or when medically  
5 necessary as determined by a physician licensed to  
6 practice medicine in all of its branches, advanced  
7 practice registered nurse, or physician assistant.

8 (4.5) For a group policy of accident and health  
9 insurance that is amended, delivered, issued, or renewed  
10 on or after the effective date of this amendatory Act of  
11 the 103rd General Assembly, molecular breast imaging (MBI)  
12 and magnetic resonance imaging of an entire breast or  
13 breasts if a mammogram demonstrates heterogeneous or dense  
14 breast tissue or when medically necessary as determined by  
15 a physician licensed to practice medicine in all of its  
16 branches, advanced practice registered nurse, or physician  
17 assistant.

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

26 A policy subject to this subsection shall not impose a

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

8 For purposes of this subsection:

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

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

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

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

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

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

9 (d-15) If a county, including a home rule county, is a  
10 self-insurer for purposes of providing health insurance  
11 coverage for its employees, the insurance coverage shall  
12 include mastectomy coverage, which includes coverage for  
13 prosthetic devices or reconstructive surgery incident to the  
14 mastectomy. Coverage for breast reconstruction in connection  
15 with a mastectomy shall include:

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

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

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

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

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

9 A county, including a home rule county, that is a  
10 self-insurer for purposes of providing health insurance  
11 coverage for its employees, may not penalize or reduce or  
12 limit the reimbursement of an attending provider or provide  
13 incentives (monetary or otherwise) to an attending provider to  
14 induce the provider to provide care to an insured in a manner  
15 inconsistent with this Section.

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

24 (e) The term "employees" as used in this Section includes  
25 elected or appointed officials but does not include temporary  
26 employees.

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

6 (g) Rulemaking authority to implement this amendatory Act  
7 of the 95th General Assembly, if any, is conditioned on the  
8 rules being adopted in accordance with all provisions of the  
9 Illinois Administrative Procedure Act and all rules and  
10 procedures of the Joint Committee on Administrative Rules; any  
11 purported rule not so adopted, for whatever reason, is  
12 unauthorized.

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

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

16 (65 ILCS 5/10-4-2) (from Ch. 24, par. 10-4-2)

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

18 (a) The corporate authorities of any municipality may  
19 arrange to provide, for the benefit of employees of the  
20 municipality, group life, health, accident, hospital, and  
21 medical insurance, or any one or any combination of those  
22 types of insurance, and may arrange to provide that insurance  
23 for the benefit of the spouses or dependents of those  
24 employees. The insurance may include provision for employees



1 or other insured persons who rely on treatment by prayer or  
2 spiritual means alone for healing in accordance with the  
3 tenets and practice of a well recognized religious  
4 denomination. The corporate authorities may provide for  
5 payment by the municipality of a portion of the premium or  
6 charge for the insurance with the employee paying the balance  
7 of the premium or charge. If the corporate authorities  
8 undertake a plan under which the municipality pays a portion  
9 of the premium or charge, the corporate authorities shall  
10 provide for withholding and deducting from the compensation of  
11 those municipal employees who consent to join the plan the  
12 balance of the premium or charge for the insurance.

13 (b) If the corporate authorities do not provide for a plan  
14 under which the municipality pays a portion of the premium or  
15 charge for a group insurance plan, the corporate authorities  
16 may provide for withholding and deducting from the  
17 compensation of those employees who consent thereto the  
18 premium or charge for any group life, health, accident,  
19 hospital, and medical insurance.

20 (c) The corporate authorities may exercise the powers  
21 granted in this Section only if the kinds of group insurance  
22 are obtained from an insurance company authorized to do  
23 business in the State of Illinois, or are obtained through an  
24 intergovernmental joint self-insurance pool as authorized  
25 under the Intergovernmental Cooperation Act. The corporate  
26 authorities may enact an ordinance prescribing the method of

1 operation of the insurance program.

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

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

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

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

20 (4) For a group policy of accident and health  
21 insurance that is amended, delivered, issued, or renewed  
22 on or after January 1, 2020 (the effective date of Public  
23 Act 101-580) ~~this amendatory Act of the 101st General~~  
24 ~~Assembly~~, a comprehensive ultrasound screening of an  
25 entire breast or breasts if a mammogram demonstrates  
26 heterogeneous or dense breast tissue or when medically

1 necessary as determined by a physician licensed to  
2 practice medicine in all of its branches.

3 (4.5) For a group policy of accident and health  
4 insurance that is amended, delivered, issued, or renewed  
5 on or after the effective date of this amendatory Act of  
6 the 103rd General Assembly, molecular breast imaging (MBI)  
7 and magnetic resonance imaging of an entire breast or  
8 breasts if a mammogram demonstrates heterogeneous or dense  
9 breast tissue or when medically necessary as determined by  
10 a physician licensed to practice medicine in all of its  
11 branches, advanced practice registered nurse, or physician  
12 assistant.

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

21 A policy subject to this subsection shall not impose a  
22 deductible, coinsurance, copayment, or any other cost-sharing  
23 requirement on the coverage provided; except that this  
24 sentence does not apply to coverage of diagnostic mammograms  
25 to the extent such coverage would disqualify a high-deductible  
26 health plan from eligibility for a health savings account

1 pursuant to Section 223 of the Internal Revenue Code (26  
2 U.S.C. 223).

3 For purposes of this subsection:

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

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

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

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

20 (d-10) When health care services are available through  
21 contracted providers and a person does not comply with plan  
22 provisions specific to the use of contracted providers, the  
23 requirements of subsection (d-5) are not applicable. When a  
24 person does not comply with plan provisions specific to the  
25 use of contracted providers, plan provisions specific to the  
26 use of non-contracted providers must be applied without

1 distinction for coverage required by this Section and shall be  
2 at least as favorable as for other radiological examinations  
3 covered by the policy or contract.

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

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

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

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

18 Care shall be determined in consultation with the attending  
19 physician and the patient. The offered coverage for prosthetic  
20 devices and reconstructive surgery shall be subject to the  
21 deductible and coinsurance conditions applied to the  
22 mastectomy, and all other terms and conditions applicable to  
23 other benefits. When a mastectomy is performed and there is no  
24 evidence of malignancy then the offered coverage may be  
25 limited to the provision of prosthetic devices and  
26 reconstructive surgery to within 2 years after the date of the

1 mastectomy. As used in this Section, "mastectomy" means the  
2 removal of all or part of the breast for medically necessary  
3 reasons, as determined by a licensed physician.

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

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

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

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

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

3 (215 ILCS 5/356g) (from Ch. 73, par. 968g)

4 Sec. 356g. Mammograms; mastectomies.

5 (a) Every insurer shall provide in each group or  
6 individual policy, contract, or certificate of insurance  
7 issued or renewed for persons who are residents of this State,  
8 coverage for screening by low-dose mammography for all  
9 patients ~~women~~ 35 years of age or older for the presence of  
10 occult breast cancer within the provisions of the policy,  
11 contract, or certificate. The coverage shall be as follows:

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

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

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

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

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

7 (4.5) For a group policy of accident and health  
8 insurance that is amended, delivered, issued, or renewed  
9 on or after the effective date of this amendatory Act of  
10 the 103rd General Assembly, molecular breast imaging (MBI)  
11 of an entire breast or breasts if a mammogram demonstrates  
12 heterogeneous or dense breast tissue or when medically  
13 necessary as determined by a physician licensed to  
14 practice medicine in all of its branches, advanced  
15 practice registered nurse, or physician assistant.

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

19 (6) For an individual or group policy of accident and  
20 health insurance or a managed care plan that is amended,  
21 delivered, issued, or renewed on or after January 1, 2020  
22 (the effective date of Public Act 101-580) ~~this amendatory~~  
23 ~~Act of the 101st General Assembly~~, a diagnostic mammogram  
24 when medically necessary, as determined by a physician  
25 licensed to practice medicine in all its branches,  
26 advanced practice registered nurse, or physician



1 assistant.

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

10 For purposes of this Section:

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

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

18 "Low-dose mammography" means the x-ray examination of the  
19 breast using equipment dedicated specifically for mammography,  
20 including the x-ray tube, filter, compression device, and  
21 image receptor, with radiation exposure delivery of less than  
22 1 rad per breast for 2 views of an average size breast. The  
23 term also includes digital mammography and includes breast  
24 tomosynthesis. As used in this Section, the term "breast  
25 tomosynthesis" means a radiologic procedure that involves the  
26 acquisition of projection images over the stationary breast to

1 produce cross-sectional digital three-dimensional images of  
2 the breast.

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

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

22 (a-10) When health care services are available through  
23 contracted providers and a person does not comply with plan  
24 provisions specific to the use of contracted providers, the  
25 requirements of subsection (a-5) are not applicable. When a  
26 person does not comply with plan provisions specific to the

1 use of contracted providers, plan provisions specific to the  
2 use of non-contracted providers must be applied without  
3 distinction for coverage required by this Section and shall be  
4 at least as favorable as for other radiological examinations  
5 covered by the policy or contract.

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

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

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

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

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

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

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

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

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

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

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

2 Sec. 4-6.1. Mammograms; mastectomies.

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

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

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

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

19 (4) For an individual or group policy of accident and  
20 health insurance or a managed care plan that is amended,  
21 delivered, issued, or renewed on or after January 1, 2020  
22 (the effective date of Public Act 101-580) ~~this amendatory~~  
23 ~~Act of the 101st General Assembly~~, a comprehensive  
24 ultrasound screening and MRI of an entire breast or  
25 breasts if a mammogram demonstrates heterogeneous or dense  
26 breast tissue or when medically necessary as determined by

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

3 (4.5) For a group policy of accident and health  
4 insurance that is amended, delivered, issued, or renewed  
5 on or after the effective date of this amendatory Act of  
6 the 103rd General Assembly, molecular breast imaging (MBI)  
7 of an entire breast or breasts if a mammogram demonstrates  
8 heterogeneous or dense breast tissue or when medically  
9 necessary as determined by a physician licensed to  
10 practice medicine in all of its branches, advanced  
11 practice registered nurse, or physician assistant.

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

21 A policy subject to this subsection shall not impose a  
22 deductible, coinsurance, copayment, or any other cost-sharing  
23 requirement on the coverage provided; except that this  
24 sentence does not apply to coverage of diagnostic mammograms  
25 to the extent such coverage would disqualify a high-deductible  
26 health plan from eligibility for a health savings account

1 pursuant to Section 223 of the Internal Revenue Code (26  
2 U.S.C. 223).

3 For purposes of this Section:

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

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

11 "Low-dose mammography" means the x-ray examination of the  
12 breast using equipment dedicated specifically for mammography,  
13 including the x-ray tube, filter, compression device, and  
14 image receptor, with radiation exposure delivery of less than  
15 1 rad per breast for 2 views of an average size breast. The  
16 term also includes digital mammography and includes breast  
17 tomosynthesis.

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

22 If, at any time, the Secretary of the United States  
23 Department of Health and Human Services, or its successor  
24 agency, promulgates rules or regulations to be published in  
25 the Federal Register or publishes a comment in the Federal  
26 Register or issues an opinion, guidance, or other action that

1 would require the State, pursuant to any provision of the  
2 Patient Protection and Affordable Care Act (Public Law  
3 111-148), including, but not limited to, 42 U.S.C.  
4 18031(d)(3)(B) or any successor provision, to defray the cost  
5 of any coverage for breast tomosynthesis outlined in this  
6 subsection, then the requirement that an insurer cover breast  
7 tomosynthesis is inoperative other than any such coverage  
8 authorized under Section 1902 of the Social Security Act, 42  
9 U.S.C. 1396a, and the State shall not assume any obligation  
10 for the cost of coverage for breast tomosynthesis set forth in  
11 this subsection.

12 (a-5) Coverage as described in subsection (a) shall be  
13 provided at no cost to the enrollee and shall not be applied to  
14 an annual or lifetime maximum benefit.

15 (b) No contract or evidence of coverage issued by a health  
16 maintenance organization that provides for the surgical  
17 procedure known as a mastectomy shall be issued, amended,  
18 delivered, or renewed in this State on or after July 3, 2001  
19 ~~(the effective date of Public Act 92-0048) this amendatory Act~~  
20 ~~of the 92nd General Assembly~~ unless that coverage also  
21 provides for prosthetic devices or reconstructive surgery  
22 incident to the mastectomy, providing that the mastectomy is  
23 performed after July 3, 2001 ~~the effective date of this~~  
24 ~~amendatory Act~~. Coverage for breast reconstruction in  
25 connection with a mastectomy shall include:

26 (1) reconstruction of the breast upon which the



1 mastectomy has been performed;

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

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

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

19 Written notice of the availability of coverage under this  
20 Section shall be delivered to the enrollee upon enrollment and  
21 annually thereafter. A health maintenance organization may not  
22 deny to an enrollee eligibility, or continued eligibility, to  
23 enroll or to renew coverage under the terms of the plan solely  
24 for the purpose of avoiding the requirements of this Section.  
25 A health maintenance organization may not penalize or reduce  
26 or limit the reimbursement of an attending provider or provide

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

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

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

12 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

13 Sec. 5-3. Insurance Code provisions.

14 (a) Health Maintenance Organizations shall be subject to  
15 the provisions of Sections 133, 134, 136, 137, 139, 140,  
16 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,  
17 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49,  
18 355.2, 355.3, 355b, 355c, 356f, 356g, 356g.5-1, 356m, 356q,  
19 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5,  
20 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,  
21 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21,  
22 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29,  
23 356z.30, 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34,  
24 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.41,  
25 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50,

1 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58,  
2 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65, 356z.67,  
3 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b,  
4 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A,  
5 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of  
6 subsection (2) of Section 367, and Articles IIA, VIII 1/2,  
7 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the  
8 Illinois Insurance Code.

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

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

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

17 (3) a corporation organized under the laws of another  
18 state, 30% or more of the enrollees of which are residents  
19 of this State, except a corporation subject to  
20 substantially the same requirements in its state of  
21 organization as is a "domestic company" under Article VIII  
22 1/2 of the Illinois Insurance Code.

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

26 (1) the Director shall give primary consideration to

1 the continuation of benefits to enrollees and the  
2 financial conditions of the acquired Health Maintenance  
3 Organization after the merger, consolidation, or other  
4 acquisition of control takes effect;

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

12 (3) the Director shall have the power to require the  
13 following information:

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

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

24 (C) a pro forma business plan detailing an  
25 acquiring party's plans with respect to the operation  
26 of the Health Maintenance Organization sought to be

1           acquired for a period of not less than 3 years; and

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

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

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

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

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

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

22          The Health Maintenance Organization shall include a  
23          statement in the evidence of coverage issued to each enrollee  
24          describing the possibility of a refund or additional premium,  
25          and upon request of any group or enrollment unit, provide to  
26          the group or enrollment unit a description of the method used

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

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

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

18 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;  
19 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.  
20 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,  
21 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;  
22 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.  
23 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,  
24 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;  
25 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.  
26 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,

1 eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

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

4 (305 ILCS 5/5-5)

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Center or other enrolled provider, as determined by the  
2 Department, through which dental services covered under this  
3 Section are performed. The Department shall establish a  
4 process for payment of claims for reimbursement for covered  
5 dental services rendered under this provision.

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

1 Department.

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

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

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

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

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

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

1 factors.

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

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

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

14 (G) Molecular breast imaging (MBI) and MRI of an  
15 entire breast or breasts if a mammogram demonstrates  
16 heterogeneous or dense breast tissue or when medically  
17 necessary as determined by a physician licensed to  
18 practice medicine in all of its branches, advanced  
19 practice registered nurse, or physician assistant.

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



1 U.S.C. 223).

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

6 For purposes of this Section:

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

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

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

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

25 If, at any time, the Secretary of the United States  
26 Department of Health and Human Services, or its successor

1 agency, promulgates rules or regulations to be published in  
2 the Federal Register or publishes a comment in the Federal  
3 Register or issues an opinion, guidance, or other action that  
4 would require the State, pursuant to any provision of the  
5 Patient Protection and Affordable Care Act (Public Law  
6 111-148), including, but not limited to, 42 U.S.C.  
7 18031(d)(3)(B) or any successor provision, to defray the cost  
8 of any coverage for breast tomosynthesis outlined in this  
9 paragraph, then the requirement that an insurer cover breast  
10 tomosynthesis is inoperative other than any such coverage  
11 authorized under Section 1902 of the Social Security Act, 42  
12 U.S.C. 1396a, and the State shall not assume any obligation  
13 for the cost of coverage for breast tomosynthesis set forth in  
14 this paragraph.

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

20 On and after January 1, 2012, providers participating in a  
21 quality improvement program approved by the Department shall  
22 be reimbursed for screening and diagnostic mammography at the  
23 same rate as the Medicare program's rates, including the  
24 increased reimbursement for digital mammography and, after  
25 January 1, 2023 (the effective date of Public Act 102-1018),  
26 breast tomosynthesis.

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

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

11          The Department shall convene an expert panel, including  
12          representatives of hospitals, free-standing breast cancer  
13          treatment centers, breast cancer quality organizations, and  
14          doctors, including radiologists that are trained in all forms  
15          of FDA approved breast imaging technologies, breast surgeons,  
16          reconstructive breast surgeons, oncologists, and primary care  
17          providers to establish quality standards for breast cancer  
18          treatment.

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

26          The Department shall establish a methodology to remind

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

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

15 The Department shall devise a means of case-managing or  
16 patient navigation for beneficiaries diagnosed with breast  
17 cancer. This program shall initially operate as a pilot  
18 program in areas of the State with the highest incidence of  
19 mortality related to breast cancer. At least one pilot program  
20 site shall be in the metropolitan Chicago area and at least one  
21 site shall be outside the metropolitan Chicago area. On or  
22 after July 1, 2016, the pilot program shall be expanded to  
23 include one site in western Illinois, one site in southern  
24 Illinois, one site in central Illinois, and 4 sites within  
25 metropolitan Chicago. An evaluation of the pilot program shall  
26 be carried out measuring health outcomes and cost of care for

1 those served by the pilot program compared to similarly  
2 situated patients who are not served by the pilot program.

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

11 The Department shall provide coverage and reimbursement  
12 for a human papillomavirus (HPV) vaccine that is approved for  
13 marketing by the federal Food and Drug Administration for all  
14 persons between the ages of 9 and 45. Subject to federal  
15 approval, the Department shall provide coverage and  
16 reimbursement for a human papillomavirus (HPV) vaccine for  
17 persons of the age of 46 and above who have been diagnosed with  
18 cervical dysplasia with a high risk of recurrence or  
19 progression. The Department shall disallow any  
20 preauthorization requirements for the administration of the  
21 human papillomavirus (HPV) vaccine.

22 On or after July 1, 2022, individuals who are otherwise  
23 eligible for medical assistance under this Article shall  
24 receive coverage for perinatal depression screenings for the  
25 12-month period beginning on the last day of their pregnancy.  
26 Medical assistance coverage under this paragraph shall be

1 conditioned on the use of a screening instrument approved by  
2 the Department.

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

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

22 The Illinois Department, in cooperation with the  
23 Departments of Human Services (as successor to the Department  
24 of Alcoholism and Substance Abuse) and Public Health, through  
25 a public awareness campaign, may provide information  
26 concerning treatment for alcoholism and drug abuse and

1 addiction, prenatal health care, and other pertinent programs  
2 directed at reducing the number of drug-affected infants born  
3 to recipients of medical assistance.

4 Neither the Department of Healthcare and Family Services  
5 nor the Department of Human Services shall sanction the  
6 recipient solely on the basis of the recipient's substance  
7 abuse.

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

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

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

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

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

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

23           Medical providers shall be required to meet certain  
24           qualifications to participate in Partnerships to ensure the  
25           delivery of high quality medical services. These  
26           qualifications shall be determined by rule of the Illinois



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

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

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

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

1 Illinois Department shall require health care providers to  
2 make available, when authorized by the patient, in writing,  
3 the medical records in a timely fashion to other health care  
4 providers who are treating or serving persons eligible for  
5 Medical Assistance under this Article. All dispensers of  
6 medical services shall be required to maintain and retain  
7 business and professional records sufficient to fully and  
8 accurately document the nature, scope, details and receipt of  
9 the health care provided to persons eligible for medical  
10 assistance under this Code, in accordance with regulations  
11 promulgated by the Illinois Department. The rules and  
12 regulations shall require that proof of the receipt of  
13 prescription drugs, dentures, prosthetic devices and  
14 eyeglasses by eligible persons under this Section accompany  
15 each claim for reimbursement submitted by the dispenser of  
16 such medical services. No such claims for reimbursement shall  
17 be approved for payment by the Illinois Department without  
18 such proof of receipt, unless the Illinois Department shall  
19 have put into effect and shall be operating a system of  
20 post-payment audit and review which shall, on a sampling  
21 basis, be deemed adequate by the Illinois Department to assure  
22 that such drugs, dentures, prosthetic devices and eyeglasses  
23 for which payment is being made are actually being received by  
24 eligible recipients. Within 90 days after September 16, 1984  
25 (the effective date of Public Act 83-1439), the Illinois  
26 Department shall establish a current list of acquisition costs

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

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

18 Notwithstanding any other law to the contrary, the  
19 Illinois Department shall, within 365 days after August 15,  
20 2014 (the effective date of Public Act 98-963), establish  
21 procedures to permit ID/DD facilities licensed under the ID/DD  
22 Community Care Act and MC/DD facilities licensed under the  
23 MC/DD Act to submit monthly billing claims for reimbursement  
24 purposes. Following development of these procedures, the  
25 Department shall have an additional 365 days to test the  
26 viability of the new system and to ensure that any necessary

1 operational or structural changes to its information  
2 technology platforms are implemented.

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

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

20 Enrollment of a vendor shall be subject to a provisional  
21 period and shall be conditional for one year. During the  
22 period of conditional enrollment, the Department may terminate  
23 the vendor's eligibility to participate in, or may disenroll  
24 the vendor from, the medical assistance program without cause.  
25 Unless otherwise specified, such termination of eligibility or  
26 disenrollment is not subject to the Department's hearing

1 process. However, a disenrolled vendor may reapply without  
2 penalty.

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

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

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

1 the conditional enrollment period.

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

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

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

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

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

25 For claims for services rendered during a period for which  
26 a recipient received retroactive eligibility, claims must be

1 filed within 180 days after the Department determines the  
2 applicant is eligible. For claims for which the Illinois  
3 Department is not the primary payer, claims must be submitted  
4 to the Illinois Department within 180 days after the final  
5 adjudication by the primary payer.

6 In the case of long term care facilities, within 120  
7 calendar days of receipt by the facility of required  
8 prescreening information, new admissions with associated  
9 admission documents shall be submitted through the Medical  
10 Electronic Data Interchange (MEDI) or the Recipient  
11 Eligibility Verification (REV) System or shall be submitted  
12 directly to the Department of Human Services using required  
13 admission forms. Effective September 1, 2014, admission  
14 documents, including all prescreening information, must be  
15 submitted through MEDI or REV. Confirmation numbers assigned  
16 to an accepted transaction shall be retained by a facility to  
17 verify timely submittal. Once an admission transaction has  
18 been completed, all resubmitted claims following prior  
19 rejection are subject to receipt no later than 180 days after  
20 the admission transaction has been completed.

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

25 To the extent consistent with applicable information and  
26 privacy, security, and disclosure laws, State and federal

1 agencies and departments shall provide the Illinois Department  
2 access to confidential and other information and data  
3 necessary to perform eligibility and payment verifications and  
4 other Illinois Department functions. This includes, but is not  
5 limited to: information pertaining to licensure;  
6 certification; earnings; immigration status; citizenship; wage  
7 reporting; unearned and earned income; pension income;  
8 employment; supplemental security income; social security  
9 numbers; National Provider Identifier (NPI) numbers; the  
10 National Practitioner Data Bank (NPDB); program and agency  
11 exclusions; taxpayer identification numbers; tax delinquency;  
12 corporate information; and death records.

13 The Illinois Department shall enter into agreements with  
14 State agencies and departments, and is authorized to enter  
15 into agreements with federal agencies and departments, under  
16 which such agencies and departments shall share data necessary  
17 for medical assistance program integrity functions and  
18 oversight. The Illinois Department shall develop, in  
19 cooperation with other State departments and agencies, and in  
20 compliance with applicable federal laws and regulations,  
21 appropriate and effective methods to share such data. At a  
22 minimum, and to the extent necessary to provide data sharing,  
23 the Illinois Department shall enter into agreements with State  
24 agencies and departments, and is authorized to enter into  
25 agreements with federal agencies and departments, including,  
26 but not limited to: the Secretary of State; the Department of



1 Revenue; the Department of Public Health; the Department of  
2 Human Services; and the Department of Financial and  
3 Professional Regulation.

4 Beginning in fiscal year 2013, the Illinois Department  
5 shall set forth a request for information to identify the  
6 benefits of a pre-payment, post-adjudication, and post-edit  
7 claims system with the goals of streamlining claims processing  
8 and provider reimbursement, reducing the number of pending or  
9 rejected claims, and helping to ensure a more transparent  
10 adjudication process through the utilization of: (i) provider  
11 data verification and provider screening technology; and (ii)  
12 clinical code editing; and (iii) pre-pay, pre-adjudicated, or  
13 post-adjudicated predictive modeling with an integrated case  
14 management system with link analysis. Such a request for  
15 information shall not be considered as a request for proposal  
16 or as an obligation on the part of the Illinois Department to  
17 take any action or acquire any products or services.

18 The Illinois Department shall establish policies,  
19 procedures, standards and criteria by rule for the  
20 acquisition, repair and replacement of orthotic and prosthetic  
21 devices and durable medical equipment. Such rules shall  
22 provide, but not be limited to, the following services: (1)  
23 immediate repair or replacement of such devices by recipients;  
24 and (2) rental, lease, purchase or lease-purchase of durable  
25 medical equipment in a cost-effective manner, taking into  
26 consideration the recipient's medical prognosis, the extent of

1 the recipient's needs, and the requirements and costs for  
2 maintaining such equipment. Subject to prior approval, such  
3 rules shall enable a recipient to temporarily acquire and use  
4 alternative or substitute devices or equipment pending repairs  
5 or replacements of any device or equipment previously  
6 authorized for such recipient by the Department.  
7 Notwithstanding any provision of Section 5-5f to the contrary,  
8 the Department may, by rule, exempt certain replacement  
9 wheelchair parts from prior approval and, for wheelchairs,  
10 wheelchair parts, wheelchair accessories, and related seating  
11 and positioning items, determine the wholesale price by  
12 methods other than actual acquisition costs.

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

21 In order to promote environmental responsibility, meet the  
22 needs of recipients and enrollees, and achieve significant  
23 cost savings, the Department, or a managed care organization  
24 under contract with the Department, may provide recipients or  
25 managed care enrollees who have a prescription or Certificate  
26 of Medical Necessity access to refurbished durable medical

1 equipment under this Section (excluding prosthetic and  
2 orthotic devices as defined in the Orthotics, Prosthetics, and  
3 Pedorthics Practice Act and complex rehabilitation technology  
4 products and associated services) through the State's  
5 assistive technology program's reutilization program, using  
6 staff with the Assistive Technology Professional (ATP)  
7 Certification if the refurbished durable medical equipment:  
8 (i) is available; (ii) is less expensive, including shipping  
9 costs, than new durable medical equipment of the same type;  
10 (iii) is able to withstand at least 3 years of use; (iv) is  
11 cleaned, disinfected, sterilized, and safe in accordance with  
12 federal Food and Drug Administration regulations and guidance  
13 governing the reprocessing of medical devices in health care  
14 settings; and (v) equally meets the needs of the recipient or  
15 enrollee. The reutilization program shall confirm that the  
16 recipient or enrollee is not already in receipt of the same or  
17 similar equipment from another service provider, and that the  
18 refurbished durable medical equipment equally meets the needs  
19 of the recipient or enrollee. Nothing in this paragraph shall  
20 be construed to limit recipient or enrollee choice to obtain  
21 new durable medical equipment or place any additional prior  
22 authorization conditions on enrollees of managed care  
23 organizations.

24 The Department shall execute, relative to the nursing home  
25 prescreening project, written inter-agency agreements with the  
26 Department of Human Services and the Department on Aging, to

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

1 community-based services in circumstances where federal  
2 approval has been granted.

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

10 The Illinois Department shall report annually to the  
11 General Assembly, no later than the second Friday in April of  
12 1979 and each year thereafter, in regard to:

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

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

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

19 (d) efforts at utilization review and control by the  
20 Illinois Department.

21 The period covered by each report shall be the 3 years  
22 ending on the June 30 prior to the report. The report shall  
23 include suggested legislation for consideration by the General  
24 Assembly. The requirement for reporting to the General  
25 Assembly shall be satisfied by filing copies of the report as  
26 required by Section 3.1 of the General Assembly Organization

1 Act, and filing such additional copies with the State  
2 Government Report Distribution Center for the General Assembly  
3 as is required under paragraph (t) of Section 7 of the State  
4 Library Act.

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

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

16 Because kidney transplantation can be an appropriate,  
17 cost-effective alternative to renal dialysis when medically  
18 necessary and notwithstanding the provisions of Section 1-11  
19 of this Code, beginning October 1, 2014, the Department shall  
20 cover kidney transplantation for noncitizens with end-stage  
21 renal disease who are not eligible for comprehensive medical  
22 benefits, who meet the residency requirements of Section 5-3  
23 of this Code, and who would otherwise meet the financial  
24 requirements of the appropriate class of eligible persons  
25 under Section 5-2 of this Code. To qualify for coverage of  
26 kidney transplantation, such person must be receiving

1 emergency renal dialysis services covered by the Department.  
2 Providers under this Section shall be prior approved and  
3 certified by the Department to perform kidney transplantation  
4 and the services under this Section shall be limited to  
5 services associated with kidney transplantation.

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

17 On or after July 1, 2015, opioid antagonists prescribed  
18 for the treatment of an opioid overdose, including the  
19 medication product, administration devices, and any pharmacy  
20 fees or hospital fees related to the dispensing, distribution,  
21 and administration of the opioid antagonist, shall be covered  
22 under the medical assistance program for persons who are  
23 otherwise eligible for medical assistance under this Article.  
24 As used in this Section, "opioid antagonist" means a drug that  
25 binds to opioid receptors and blocks or inhibits the effect of  
26 opioids acting on those receptors, including, but not limited

1 to, naloxone hydrochloride or any other similarly acting drug  
2 approved by the U.S. Food and Drug Administration. The  
3 Department shall not impose a copayment on the coverage  
4 provided for naloxone hydrochloride under the medical  
5 assistance program.

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

18 A federally qualified health center, as defined in Section  
19 1905(1)(2)(B) of the federal Social Security Act, shall be  
20 reimbursed by the Department in accordance with the federally  
21 qualified health center's encounter rate for services provided  
22 to medical assistance recipients that are performed by a  
23 dental hygienist, as defined under the Illinois Dental  
24 Practice Act, working under the general supervision of a  
25 dentist and employed by a federally qualified health center.

26 Within 90 days after October 8, 2021 (the effective date



1 of Public Act 102-665), the Department shall seek federal  
2 approval of a State Plan amendment to expand coverage for  
3 family planning services that includes presumptive eligibility  
4 to individuals whose income is at or below 208% of the federal  
5 poverty level. Coverage under this Section shall be effective  
6 beginning no later than December 1, 2022.

7 Subject to approval by the federal Centers for Medicare  
8 and Medicaid Services of a Title XIX State Plan amendment  
9 electing the Program of All-Inclusive Care for the Elderly  
10 (PACE) as a State Medicaid option, as provided for by Subtitle  
11 I (commencing with Section 4801) of Title IV of the Balanced  
12 Budget Act of 1997 (Public Law 105-33) and Part 460  
13 (commencing with Section 460.2) of Subchapter E of Title 42 of  
14 the Code of Federal Regulations, PACE program services shall  
15 become a covered benefit of the medical assistance program,  
16 subject to criteria established in accordance with all  
17 applicable laws.

18 Notwithstanding any other provision of this Code,  
19 community-based pediatric palliative care from a trained  
20 interdisciplinary team shall be covered under the medical  
21 assistance program as provided in Section 15 of the Pediatric  
22 Palliative Care Act.

23 Notwithstanding any other provision of this Code, within  
24 12 months after June 2, 2022 (the effective date of Public Act  
25 102-1037) and subject to federal approval, acupuncture  
26 services performed by an acupuncturist licensed under the

1 Acupuncture Practice Act who is acting within the scope of his  
2 or her license shall be covered under the medical assistance  
3 program. The Department shall apply for any federal waiver or  
4 State Plan amendment, if required, to implement this  
5 paragraph. The Department may adopt any rules, including  
6 standards and criteria, necessary to implement this paragraph.

7 Notwithstanding any other provision of this Code, the  
8 medical assistance program shall, subject to appropriation and  
9 federal approval, reimburse hospitals for costs associated  
10 with a newborn screening test for the presence of  
11 metachromatic leukodystrophy, as required under the Newborn  
12 Metabolic Screening Act, at a rate not less than the fee  
13 charged by the Department of Public Health. The Department  
14 shall seek federal approval before the implementation of the  
15 newborn screening test fees by the Department of Public  
16 Health.

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

25 Notwithstanding any other provision of this Code,  
26 medically necessary reconstructive services that are intended

1 to restore physical appearance shall be covered under the  
2 medical assistance program for persons who are otherwise  
3 eligible for medical assistance under this Article. As used in  
4 this paragraph, "reconstructive services" means treatments  
5 performed on structures of the body damaged by trauma to  
6 restore physical appearance.

7 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;  
8 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article  
9 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,  
10 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;  
11 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.  
12 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;  
13 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.  
14 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;  
15 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.  
16 1-1-24; revised 12-15-23.)

17 Section 99. Effective date. This Act takes effect January  
18 1, 2026."