1 AN ACT concerning regulation.

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

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

6 (55 ILCS 5/5-1069) (from Ch. 34, par. 5-1069)
7 Sec. 5-1069. Group life, health, accident, hospital, and
8 medical insurance.
9 (a) The county board of any county may arrange to provide,
10 for the benefit of employees of the county, group life,
11 health, accident, hospital, and medical insurance, or any one
12 or any combination of those types of insurance, or the county
13 board may self-insure, for the benefit of its employees, all
14 or a portion of the employees' group life, health, accident,
15 hospital, and medical insurance, or any one or any combination
16 of those types of insurance, including a combination of
17 self-insurance and other types of insurance authorized by this
18 Section, provided that the county board complies with all
19 other requirements of this Section. The insurance may include
20 provision for employees who rely on treatment by prayer or
21 spiritual means alone for healing in accordance with the
22 tenets and practice of a well recognized religious
23 denomination. The county board may provide for payment by the

1 county of a portion or all of the premium or charge for the
2 insurance with the employee paying the balance of the premium
3 or charge, if any. If the county board undertakes a plan under
4 which the county pays only a portion of the premium or charge,
5 the county board shall provide for withholding and deducting
6 from the compensation of those employees who consent to join
7 the plan the balance of the premium or charge for the
8 insurance.
9 (b) If the county board does not provide for
10 self-insurance or for a plan under which the county pays a
11 portion or all of the premium or charge for a group insurance
12 plan, the county board may provide for withholding and
13 deducting from the compensation of those employees who consent
14 thereto the total premium or charge for any group life,
15 health, accident, hospital, and medical insurance.
16 (c) The county board may exercise the powers granted in
17 this Section only if it provides for self-insurance or, where
18 it makes arrangements to provide group insurance through an
19 insurance carrier, if the kinds of group insurance are
20 obtained from an insurance company authorized to do business
21 in the State of Illinois. The county board may enact an
22 ordinance prescribing the method of operation of the insurance
23 program.
24 (d) If a county, including a home rule county, is a
25 self-insurer for purposes of providing health insurance
26 coverage for its employees, the insurance coverage shall

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

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

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

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

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

(4.5) For a group policy of accident and health

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

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

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

For purposes of this subsection:

1 "Diagnostic mammogram" means a mammogram obtained using
2 diagnostic mammography.
3 "Diagnostic mammography" means a method of screening that
4 is designed to evaluate an abnormality in a breast, including
5 an abnormality seen or suspected on a screening mammogram or a
6 subjective or objective abnormality otherwise detected in the
7 breast.
8 "Low-dose mammography" means the x-ray examination of the
9 breast using equipment dedicated specifically for mammography,
10 including the x-ray tube, filter, compression device, and
11 image receptor, with an average radiation exposure delivery of
12 less than one rad per breast for 2 views of an average size
13 breast. The term also includes digital mammography.
14 (d-5) Coverage as described by subsection (d) shall be
15 provided at no cost to the insured and shall not be applied to
16 an annual or lifetime maximum benefit.
17 (d-10) When health care services are available through
18 contracted providers and a person does not comply with plan
19 provisions specific to the use of contracted providers, the
20 requirements of subsection (d-5) are not applicable. When a
21 person does not comply with plan provisions specific to the
22 use of contracted providers, plan provisions specific to the
23 use of non-contracted providers must be applied without
24 distinction for coverage required by this Section and shall be
25 at least as favorable as for other radiological examinations
26 covered by the policy or contract.

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

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

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

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

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

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

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

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

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

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

1 Illinois Administrative Procedure Act and all rules and
2 procedures of the Joint Committee on Administrative Rules; any
3 purported rule not so adopted, for whatever reason, is
4 unauthorized.
5 (Source: P.A. 100-513, eff. 1-1-18; 101-580, eff. 1-1-20.)

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

8 (65 ILCS 5/10-4-2) (from Ch. 24, par. 10-4-2)
9 Sec. 10-4-2. Group insurance.
10 (a) The corporate authorities of any municipality may
11 arrange to provide, for the benefit of employees of the
12 municipality, group life, health, accident, hospital, and
13 medical insurance, or any one or any combination of those
14 types of insurance, and may arrange to provide that insurance
15 for the benefit of the spouses or dependents of those
16 employees. The insurance may include provision for employees
17 or other insured persons who rely on treatment by prayer or
18 spiritual means alone for healing in accordance with the
19 tenets and practice of a well recognized religious
20 denomination. The corporate authorities may provide for
21 payment by the municipality of a portion of the premium or
22 charge for the insurance with the employee paying the balance
23 of the premium or charge. If the corporate authorities
24 undertake a plan under which the municipality pays a portion

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

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

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

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

be as follows:

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

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

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

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

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

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

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

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

For purposes of this subsection:

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

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

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

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

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

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

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

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

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

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

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

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

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

1 induce the provider to provide care to an insured in a manner
2 inconsistent with this Section.
3 (d-20) The requirement that mammograms be included in
4 health insurance coverage as provided in subsections (d)
5 through (d-15) is an exclusive power and function of the State
6 and is a denial and limitation under Article VII, Section 6,
7 subsection (h) of the Illinois Constitution of home rule
8 municipality powers. A home rule municipality to which
9 subsections (d) through (d-15) apply must comply with every
10 provision of those subsections.
11 (e) Rulemaking authority to implement Public Act 95-1045,
12 if any, is conditioned on the rules being adopted in
13 accordance with all provisions of the Illinois Administrative
14 Procedure Act and all rules and procedures of the Joint
15 Committee on Administrative Rules; any purported rule not so
16 adopted, for whatever reason, is unauthorized.
17 (Source: P.A. 100-863, eff. 8-14-18; 101-580, eff. 1-1-20.)

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

20 (215 ILCS 5/356g) (from Ch. 73, par. 968g)
21 Sec. 356g. Mammograms; mastectomies.
22 (a) Every insurer shall provide in each group or
23 individual policy, contract, or certificate of insurance
24 issued or renewed for persons who are residents of this State,

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

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

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

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

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

(4.5) For a group policy of accident and health insurance that is amended, delivered, issued, or renewed

on or after the effective date of this amendatory Act of the 103rd General Assembly, molecular breast imaging (MBI) of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when medically necessary as determined by a physician licensed to practice medicine in all of its branches, advanced practice registered nurse, or physician assistant.

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

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

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

U.S.C. 223).

For purposes of this Section:

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

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

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

If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, promulgates rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, pursuant to any provision of the

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

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

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

24 (b) No policy of accident or health insurance that
25 provides for the surgical procedure known as a mastectomy
26 shall be issued, amended, delivered, or renewed in this State

1 unless that coverage also provides for prosthetic devices or
2 reconstructive surgery incident to the mastectomy. Coverage
3 for breast reconstruction in connection with a mastectomy
4 shall include:
5 (1) reconstruction of the breast upon which the
6 mastectomy has been performed;
7 (2) surgery and reconstruction of the other breast to
8 produce a symmetrical appearance; and
9 (3) prostheses and treatment for physical
10 complications at all stages of mastectomy, including
11 lymphedemas.
12 Care shall be determined in consultation with the attending
13 physician and the patient. The offered coverage for prosthetic
14 devices and reconstructive surgery shall be subject to the
15 deductible and coinsurance conditions applied to the
16 mastectomy, and all other terms and conditions applicable to
17 other benefits. When a mastectomy is performed and there is no
18 evidence of malignancy then the offered coverage may be
19 limited to the provision of prosthetic devices and
20 reconstructive surgery to within 2 years after the date of the
21 mastectomy. As used in this Section, "mastectomy" means the
22 removal of all or part of the breast for medically necessary
23 reasons, as determined by a licensed physician.
24 Written notice of the availability of coverage under this
25 Section shall be delivered to the insured upon enrollment and
26 annually thereafter. An insurer may not deny to an insured

eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan solely for the purpose of avoiding the requirements of this Section. An insurer may not penalize or reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with this Section.

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

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

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

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

Sec. 4-6.1. Mammograms; mastectomies.

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

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

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

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

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

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

necessary as determined by a physician licensed to practice medicine in all of its branches, advanced practice registered nurse, or physician assistant.

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

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

For purposes of this Section:

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

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

subjective or objective abnormality otherwise detected in the breast.

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

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

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

U.S.C. 1396a, and the State shall not assume any obligation for the cost of coverage for breast tomosynthesis set forth in this subsection.

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

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

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

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

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

Care shall be determined in consultation with the attending physician and the patient. The offered coverage for prosthetic

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

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

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

1 purported rule not so adopted, for whatever reason, is
2 unauthorized.
3 (Source: P.A. 100-395, eff. 1-1-18; 101-580, eff. 1-1-20.)

4 (215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)
5 Sec. 5-3. Insurance Code provisions.
6 (a) Health Maintenance Organizations shall be subject to
7 the provisions of Sections 133, 134, 136, 137, 139, 140,
8 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153,
9 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 155.49,
10 355.2, 355.3, 355b, 355c, 356f, 356g, 356g.5-1, 356m, 356q,
11 356v, 356w, 356x, 356z.2, 356z.3a, 356z.4, 356z.4a, 356z.5,
12 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13,
13 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.20, 356z.21,
14 356z.22, 356z.23, 356z.24, 356z.25, 356z.26, 356z.28, 356z.29,
15 356z.30, 356z.30a, 356z.31, 356z.32, 356z.33, 356z.34,
16 356z.35, 356z.36, 356z.37, 356z.38, 356z.39, 356z.40, 356z.41,
17 356z.44, 356z.45, 356z.46, 356z.47, 356z.48, 356z.49, 356z.50,
18 356z.51, 356z.53, 356z.54, 356z.55, 356z.56, 356z.57, 356z.58,
19 356z.59, 356z.60, 356z.61, 356z.62, 356z.64, 356z.65, 356z.67,
20 356z.68, 364, 364.01, 364.3, 367.2, 367.2-5, 367i, 368a, 368b,
21 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A,
22 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of
23 subsection (2) of Section 367, and Articles IIA, VIII 1/2,
24 XII, XII 1/2, XIII, XIII 1/2, XXV, XXVI, and XXXIIB of the
25 Illinois Insurance Code.

1 (b) For purposes of the Illinois Insurance Code, except
2 for Sections 444 and 444.1 and Articles XIII and XIII 1/2,
3 Health Maintenance Organizations in the following categories
4 are deemed to be "domestic companies":
5 (1) a corporation authorized under the Dental Service
6 Plan Act or the Voluntary Health Services Plans Act;
7 (2) a corporation organized under the laws of this
8 State; or
9 (3) a corporation organized under the laws of another
10 state, 30% or more of the enrollees of which are residents
11 of this State, except a corporation subject to
12 substantially the same requirements in its state of
13 organization as is a "domestic company" under Article VIII
14 1/2 of the Illinois Insurance Code.
15 (c) In considering the merger, consolidation, or other
16 acquisition of control of a Health Maintenance Organization
17 pursuant to Article VIII 1/2 of the Illinois Insurance Code,
18 (1) the Director shall give primary consideration to
19 the continuation of benefits to enrollees and the
20 financial conditions of the acquired Health Maintenance
21 Organization after the merger, consolidation, or other
22 acquisition of control takes effect;
23 (2)(i) the criteria specified in subsection (1)(b) of
24 Section 131.8 of the Illinois Insurance Code shall not
25 apply and (ii) the Director, in making his determination
26 with respect to the merger, consolidation, or other

acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

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

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

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

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

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

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

1 to its health care certificates).
2 (e) In considering any management contract or service
3 agreement subject to Section 141.1 of the Illinois Insurance
4 Code, the Director (i) shall, in addition to the criteria
5 specified in Section 141.2 of the Illinois Insurance Code,
6 take into account the effect of the management contract or
7 service agreement on the continuation of benefits to enrollees
8 and the financial condition of the health maintenance
9 organization to be managed or serviced, and (ii) need not take
10 into account the effect of the management contract or service
11 agreement on competition.
12 (f) Except for small employer groups as defined in the
13 Small Employer Rating, Renewability and Portability Health
14 Insurance Act and except for medicare supplement policies as
15 defined in Section 363 of the Illinois Insurance Code, a
16 Health Maintenance Organization may by contract agree with a
17 group or other enrollment unit to effect refunds or charge
18 additional premiums under the following terms and conditions:
19 (i) the amount of, and other terms and conditions with
20 respect to, the refund or additional premium are set forth
21 in the group or enrollment unit contract agreed in advance
22 of the period for which a refund is to be paid or
23 additional premium is to be charged (which period shall
24 not be less than one year); and
25 (ii) the amount of the refund or additional premium
26 shall not exceed 20% of the Health Maintenance

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

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

26 In no event shall the Illinois Health Maintenance

1 Organization Guaranty Association be liable to pay any
2 contractual obligation of an insolvent organization to pay any
3 refund authorized under this Section.

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

10 (Source: P.A. 102-30, eff. 1-1-22; 102-34, eff. 6-25-21;
11 102-203, eff. 1-1-22; 102-306, eff. 1-1-22; 102-443, eff.
12 1-1-22; 102-589, eff. 1-1-22; 102-642, eff. 1-1-22; 102-665,
13 eff. 10-8-21; 102-731, eff. 1-1-23; 102-775, eff. 5-13-22;
14 102-804, eff. 1-1-23; 102-813, eff. 5-13-22; 102-816, eff.
15 1-1-23; 102-860, eff. 1-1-23; 102-901, eff. 7-1-22; 102-1093,
16 eff. 1-1-23; 102-1117, eff. 1-13-23; 103-84, eff. 1-1-24;
17 103-91, eff. 1-1-24; 103-123, eff. 1-1-24; 103-154, eff.
18 6-30-23; 103-420, eff. 1-1-24; 103-426, eff. 8-4-23; 103-445,
19 eff. 1-1-24; 103-551, eff. 8-11-23; revised 8-29-23.)

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

22 (305 ILCS 5/5-5)

23 Sec. 5-5. Medical services. The Illinois Department, by
24 rule, shall determine the quantity and quality of and the rate

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

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

23 Notwithstanding any other provision of this Section, a
24 comprehensive tobacco use cessation program that includes
25 purchasing prescription drugs or prescription medical devices
26 approved by the Food and Drug Administration shall be covered

1 under the medical assistance program under this Article for
2 persons who are otherwise eligible for assistance under this
3 Article.

4 Notwithstanding any other provision of this Code,
5 reproductive health care that is otherwise legal in Illinois
6 shall be covered under the medical assistance program for
7 persons who are otherwise eligible for medical assistance
8 under this Article.

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

1 understanding or interagency agreement, the cost allocation
2 plan, and all other necessary documentation to the Centers for
3 Medicare and Medicaid Services for review and approval.
4 Coverage under this paragraph shall be contingent upon federal
5 approval.

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

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

KIDS Health Insurance Program shall be submitted to the Department or the MCE in which the individual is enrolled for payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

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

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

24 On and after January 1, 2022, the Department of Healthcare
25 and Family Services shall administer and regulate a
26 school-based dental program that allows for the out-of-office

delivery of preventative dental services in a school setting to children under 19 years of age. The Department shall establish, by rule, guidelines for participation by providers and set requirements for follow-up referral care based on the requirements established in the Dental Office Reference Manual published by the Department that establishes the requirements for dentists participating in the All Kids Dental School Program. Every effort shall be made by the Department when developing the program requirements to consider the different geographic differences of both urban and rural areas of the State for initial treatment and necessary follow-up care. No provider shall be charged a fee by any unit of local government to participate in the school-based dental program administered by the Department. Nothing in this paragraph shall be construed to limit or preempt a home rule unit's or school district's authority to establish, change, or administer a school-based dental program in addition to, or independent of, the school-based dental program administered by the Department.

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

The Department of Healthcare and Family Services must provide coverage and reimbursement for amino acid-based elemental formulas, regardless of delivery method, for the

diagnosis and treatment of (i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

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

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

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

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

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

(E) A screening MRI when medically necessary, as determined by a physician licensed to practice medicine in

1 all of its branches.
2 (F) A diagnostic mammogram when medically necessary,
3 as determined by a physician licensed to practice medicine
4 in all its branches, advanced practice registered nurse,
5 or physician assistant.
6 (G) Molecular breast imaging (MBI) and MRI of an
7 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 The Department shall not impose a deductible, coinsurance,
13 copayment, or any other cost-sharing requirement on the
14 coverage provided under this paragraph; except that this
15 sentence does not apply to coverage of diagnostic mammograms
16 to the extent such coverage would disqualify a high-deductible
17 health plan from eligibility for a health savings account
18 pursuant to Section 223 of the Internal Revenue Code (26
19 U.S.C. 223).
20 All screenings shall include a physical breast exam,
21 instruction on self-examination and information regarding the
22 frequency of self-examination and its value as a preventative
23 tool.
24 For purposes of this Section:
25 "Diagnostic mammogram" means a mammogram obtained using
26 diagnostic mammography.

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

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

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

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

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

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

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

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

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

program's rates for the data elements included in the breast cancer treatment quality program.

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

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

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

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

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

21 The Department shall require all networks of care to
22 develop a means either internally or by contract with experts
23 in navigation and community outreach to navigate cancer
24 patients to comprehensive care in a timely fashion. The
25 Department shall require all networks of care to include
26 access for patients diagnosed with cancer to at least one

academic commission on cancer-accredited cancer program as an in-network covered benefit.

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

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

Any medical or health care provider shall immediately recommend, to any pregnant individual who is being provided prenatal services and is suspected of having a substance use disorder as defined in the Substance Use Disorder Act, referral to a local substance use disorder treatment program licensed by the Department of Human Services or to a licensed

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

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

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

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

26 The Illinois Department shall establish such regulations

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

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

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

in target areas according to provisions of this Article and the Illinois Health Finance Reform Act, except that:

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

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

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

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

Nothing in this Section shall limit the free choice of practitioners, hospitals, and other providers of medical services by clients. In order to ensure patient freedom of

choice, the Illinois Department shall immediately promulgate all rules and take all other necessary actions so that provided services may be accessed from therapeutically certified optometrists to the full extent of the Illinois Optometric Practice Act of 1987 without discriminating between service providers.

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

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

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

25 Notwithstanding any other law to the contrary, the
26 Illinois Department shall, within 365 days after July 22, 2013

1 (the effective date of Public Act 98-104), establish
2 procedures to permit skilled care facilities licensed under
3 the Nursing Home Care Act to submit monthly billing claims for
4 reimbursement purposes. Following development of these
5 procedures, the Department shall, by July 1, 2016, test the
6 viability of the new system and implement any necessary
7 operational or structural changes to its information
8 technology platforms in order to allow for the direct
9 acceptance and payment of nursing home claims.
10 Notwithstanding any other law to the contrary, the
11 Illinois Department shall, within 365 days after August 15,
12 2014 (the effective date of Public Act 98-963), establish
13 procedures to permit ID/DD facilities licensed under the ID/DD
14 Community Care Act and MC/DD facilities licensed under the
15 MC/DD Act to submit monthly billing claims for reimbursement
16 purposes. Following development of these procedures, the
17 Department shall have an additional 365 days to test the
18 viability of the new system and to ensure that any necessary
19 operational or structural changes to its information
20 technology platforms are implemented.
21 The Illinois Department shall require all dispensers of
22 medical services, other than an individual practitioner or
23 group of practitioners, desiring to participate in the Medical
24 Assistance program established under this Article to disclose
25 all financial, beneficial, ownership, equity, surety or other
26 interests in any and all firms, corporations, partnerships,

associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services in this State under this Article.

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

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

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

Prior to enrollment and during the conditional enrollment period in the medical assistance program, all vendors shall be subject to enhanced oversight, screening, and review based on

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

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

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

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

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

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

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

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

In the case of long term care facilities, within 120 calendar days of receipt by the facility of required prescreening information, new admissions with associated

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

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

To the extent consistent with applicable information and privacy, security, and disclosure laws, State and federal agencies and departments shall provide the Illinois Department access to confidential and other information and data necessary to perform eligibility and payment verifications and other Illinois Department functions. This includes, but is not limited to: information pertaining to licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security

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

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

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

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

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

wheelchair parts from prior approval and, for wheelchairs, wheelchair parts, wheelchair accessories, and related seating and positioning items, determine the wholesale price by methods other than actual acquisition costs.

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

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

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

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

1 37 for applicants for institutional and home and
2 community-based long term care; if and only if federal
3 approval is not granted, the Department may, in conjunction
4 with other affected agencies, implement utilization controls
5 or changes in benefit packages to effectuate a similar savings
6 amount for this population; and (iv) no later than July 1,
7 2013, minimum level of care eligibility criteria for
8 institutional and home and community-based long term care; and
9 (v) no later than October 1, 2013, establish procedures to
10 permit long term care providers access to eligibility scores
11 for individuals with an admission date who are seeking or
12 receiving services from the long term care provider. In order
13 to select the minimum level of care eligibility criteria, the
14 Governor shall establish a workgroup that includes affected
15 agency representatives and stakeholders representing the
16 institutional and home and community-based long term care
17 interests. This Section shall not restrict the Department from
18 implementing lower level of care eligibility criteria for
19 community-based services in circumstances where federal
20 approval has been granted.

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

1 medical assistance under this Code.
2 The Illinois Department shall report annually to the
3 General Assembly, no later than the second Friday in April of
4 1979 and each year thereafter, in regard to:
5 (a) actual statistics and trends in utilization of
6 medical services by public aid recipients;
7 (b) actual statistics and trends in the provision of
8 the various medical services by medical vendors;
9 (c) current rate structures and proposed changes in
10 those rate structures for the various medical vendors; and
11 (d) efforts at utilization review and control by the
12 Illinois Department.
13 The period covered by each report shall be the 3 years
14 ending on the June 30 prior to the report. The report shall
15 include suggested legislation for consideration by the General
16 Assembly. The requirement for reporting to the General
17 Assembly shall be satisfied by filing copies of the report as
18 required by Section 3.1 of the General Assembly Organization
19 Act, and filing such additional copies with the State
20 Government Report Distribution Center for the General Assembly
21 as is required under paragraph (t) of Section 7 of the State
22 Library Act.
23 Rulemaking authority to implement Public Act 95-1045, if
24 any, is conditioned on the rules being adopted in accordance
25 with all provisions of the Illinois Administrative Procedure
26 Act and all rules and procedures of the Joint Committee on

1 Administrative Rules; any purported rule not so adopted, for
2 whatever reason, is unauthorized.

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

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

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

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

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

Upon federal approval, the Department shall provide coverage and reimbursement for all drugs that are approved for marketing by the federal Food and Drug Administration and that

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

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

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

25 Subject to approval by the federal Centers for Medicare
26 and Medicaid Services of a Title XIX State Plan amendment

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

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

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

25 Notwithstanding any other provision of this Code, the
26 medical assistance program shall, subject to appropriation and

1 federal approval, reimburse hospitals for costs associated
2 with a newborn screening test for the presence of
3 metachromatic leukodystrophy, as required under the Newborn
4 Metabolic Screening Act, at a rate not less than the fee
5 charged by the Department of Public Health. The Department
6 shall seek federal approval before the implementation of the
7 newborn screening test fees by the Department of Public
8 Health.

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

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

25 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;
26 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article

1 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,
2 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;
3 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.
4 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;
5 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.
6 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;
7 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.
8 1-1-24; revised 12-15-23.)

9 Section 99. Effective date. This Act takes effect January
10 1, 2026.