



## 104TH GENERAL ASSEMBLY

### State of Illinois

2025 and 2026

HB4215

Introduced 1/14/2026, by Rep. Diane Blair-Sherlock and Michelle Mussman

#### SYNOPSIS AS INTRODUCED:

|                        |                               |
|------------------------|-------------------------------|
| 20 ILCS 2310/2310-90   | was 20 ILCS 2310/55.09        |
| 30 ILCS 500/1-10       |                               |
| 305 ILCS 5/5-5         |                               |
| 410 ILCS 240/Act title |                               |
| 410 ILCS 240/0.01      | from Ch. 111 1/2, par. 4902.9 |
| 410 ILCS 240/2         | from Ch. 111 1/2, par. 4904   |
| 410 ILCS 513/30        |                               |

Amends the Newborn Metabolic Screening Act. Changes the short title of the Act to the Newborn Screening Act. Specifies that, for purposes of the Act, hearing disorders are a genetic, metabolic, or congenital anomaly for which newborns must be screened. Provides that, beginning July 1, 2026, the base fee for newborn screening services shall be \$165. Provides that 22% of the base fee must be allocated to the Department of Public Health for the Early Hearing Detection and Intervention Program. Provides that other State and federal funds for expenses related to metabolic, hearing, or congenital disorder screening, follow-up, and treatment programs (rather than only metabolic screening, follow-up, and treatment programs) may also be placed in the Metabolic Screening and Treatment Fund. In provisions concerning the temporary testing of all blood and biological specimens, excludes hearing screenings. Makes conforming and technical changes to the title of the Act, the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois, the Illinois Procurement Code, the Illinois Public Aid Code, and the Genetic Information Privacy Act. Effective immediately.

LRB104 15597 BDA 28764 b

1 AN ACT concerning health.

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

4 Section 5. The Department of Public Health Powers and  
5 Duties Law of the Civil Administrative Code of Illinois is  
6 amended by changing Section 2310-90 as follows:

7 (20 ILCS 2310/2310-90) (was 20 ILCS 2310/55.09)

8 Sec. 2310-90. Laboratories; fees; Public Health Laboratory  
9 Services Revolving Fund. To maintain physical, chemical,  
10 bacteriological, and biological laboratories; to make  
11 examinations of milk, water, atmosphere, sewage, wastes, and  
12 other substances, and equipment and processes relating  
13 thereto; to make diagnostic tests for diseases and tests for  
14 the evaluation of health hazards considered necessary for the  
15 protection of the people of the State; and to assess a  
16 reasonable fee for services provided as established by  
17 regulation, under the Illinois Administrative Procedure Act,  
18 which shall not exceed the Department's actual costs to  
19 provide these services.

20 Excepting fees collected under the Newborn ~~Metabolic~~  
21 Screening Act and the Lead Poisoning Prevention Act, all fees  
22 shall be deposited into the Public Health Laboratory Services  
23 Revolving Fund. Other State and federal funds related to

1 laboratory services may also be deposited into the Fund, and  
2 all interest that accrues on the moneys in the Fund shall be  
3 deposited into the Fund.

4 Moneys shall be appropriated from the Fund solely for the  
5 purposes of testing specimens submitted in support of  
6 Department programs established for the protection of human  
7 health, welfare, and safety, and for testing specimens  
8 submitted by physicians and other health care providers, to  
9 determine whether chemically hazardous, biologically  
10 infectious substances, or other disease causing conditions are  
11 present.

12 (Source: P.A. 96-328, eff. 8-11-09.)

13 Section 10. The Illinois Procurement Code is amended by  
14 changing Section 1-10 as follows:

15 (30 ILCS 500/1-10)

16 Sec. 1-10. Application.

17 (a) This Code applies only to procurements for which  
18 bidders, offerors, potential contractors, or contractors were  
19 first solicited on or after July 1, 1998. This Code shall not  
20 be construed to affect or impair any contract, or any  
21 provision of a contract, entered into based on a solicitation  
22 prior to the implementation date of this Code as described in  
23 Article 99, including, but not limited to, any covenant  
24 entered into with respect to any revenue bonds or similar

1 instruments. All procurements for which contracts are  
2 solicited between the effective date of Articles 50 and 99 and  
3 July 1, 1998 shall be substantially in accordance with this  
4 Code and its intent.

5 (b) This Code shall apply regardless of the source of the  
6 funds with which the contracts are paid, including federal  
7 assistance moneys. This Code shall not apply to:

8 (1) Contracts between the State and its political  
9 subdivisions or other governments, or between State  
10 governmental bodies, except as specifically provided in  
11 this Code.

12 (2) Grants, except for the filing requirements of  
13 Section 20-80.

14 (3) Purchase of care, except as provided in Section  
15 5-30.6 of the Illinois Public Aid Code and this Section.

16 (4) Hiring of an individual as an employee and not as  
17 an independent contractor, whether pursuant to an  
18 employment code or policy or by contract directly with  
19 that individual.

20 (5) Collective bargaining contracts.

21 (6) Purchase of real estate, except that notice of  
22 this type of contract with a value of more than \$25,000  
23 must be published in the Procurement Bulletin within 10  
24 calendar days after the deed is recorded in the county of  
25 jurisdiction. The notice shall identify the real estate  
26 purchased, the names of all parties to the contract, the

1 value of the contract, and the effective date of the  
2 contract.

3 (7) Contracts necessary to prepare for anticipated  
4 litigation, enforcement actions, or investigations,  
5 provided that the chief legal counsel to the Governor  
6 shall give his or her prior approval when the procuring  
7 agency is one subject to the jurisdiction of the Governor,  
8 and provided that the chief legal counsel of any other  
9 procuring entity subject to this Code shall give his or  
10 her prior approval when the procuring entity is not one  
11 subject to the jurisdiction of the Governor.

12 (8) (Blank).

13 (9) Procurement expenditures by the Illinois  
14 Conservation Foundation when only private funds are used.

15 (10) (Blank).

16 (11) Public-private agreements entered into according  
17 to the procurement requirements of Section 20 of the  
18 Public-Private Partnerships for Transportation Act and  
19 design-build agreements entered into according to the  
20 procurement requirements of Section 25 of the  
21 Public-Private Partnerships for Transportation Act.

22 (12) (A) Contracts for legal, financial, and other  
23 professional and artistic services entered into by the  
24 Illinois Finance Authority in which the State of Illinois  
25 is not obligated. Such contracts shall be awarded through  
26 a competitive process authorized by the members of the

1 Illinois Finance Authority and are subject to Sections  
2 5-30, 20-160, 50-13, 50-20, 50-35, and 50-37 of this Code,  
3 as well as the final approval by the members of the  
4 Illinois Finance Authority of the terms of the contract.

5 (B) Contracts for legal and financial services entered  
6 into by the Illinois Housing Development Authority in  
7 connection with the issuance of bonds in which the State  
8 of Illinois is not obligated. Such contracts shall be  
9 awarded through a competitive process authorized by the  
10 members of the Illinois Housing Development Authority and  
11 are subject to Sections 5-30, 20-160, 50-13, 50-20, 50-35,  
12 and 50-37 of this Code, as well as the final approval by  
13 the members of the Illinois Housing Development Authority  
14 of the terms of the contract.

15 (13) Contracts for services, commodities, and  
16 equipment to support the delivery of timely forensic  
17 science services in consultation with and subject to the  
18 approval of the Chief Procurement Officer as provided in  
19 subsection (d) of Section 5-4-3a of the Unified Code of  
20 Corrections, except for the requirements of Sections  
21 20-60, 20-65, 20-70, and 20-160 and Article 50 of this  
22 Code; however, the Chief Procurement Officer may, in  
23 writing with justification, waive any certification  
24 required under Article 50 of this Code. For any contracts  
25 for services which are currently provided by members of a  
26 collective bargaining agreement, the applicable terms of

1       the       collective       bargaining       agreement       concerning  
2       subcontracting shall be followed.

3           On and after January 1, 2019, this paragraph (13),  
4       except for this sentence, is inoperative.

5           (14) Contracts for participation expenditures required  
6       by a domestic or international trade show or exhibition of  
7       an exhibitor, member, or sponsor.

8           (15) Contracts with a railroad or utility that  
9       requires the State to reimburse the railroad or utilities  
10      for the relocation of utilities for construction or other  
11      public purpose. Contracts included within this paragraph  
12      (15) shall include, but not be limited to, those  
13      associated with: relocations, crossings, installations,  
14      and maintenance. For the purposes of this paragraph (15),  
15      "railroad" means any form of non-highway ground  
16      transportation that runs on rails or electromagnetic  
17      guideways and "utility" means: (1) public utilities as  
18      defined in Section 3-105 of the Public Utilities Act, (2)  
19      telecommunications carriers as defined in Section 13-202  
20      of the Public Utilities Act, (3) electric cooperatives as  
21      defined in Section 3.4 of the Electric Supplier Act, (4)  
22      telephone or telecommunications cooperatives as defined in  
23      Section 13-212 of the Public Utilities Act, (5) rural  
24      water or waste water systems with 10,000 connections or  
25      less, (6) a holder as defined in Section 21-201 of the  
26      Public Utilities Act, and (7) municipalities owning or

1 operating utility systems consisting of public utilities  
2 as that term is defined in Section 11-117-2 of the  
3 Illinois Municipal Code.

4 (16) Procurement expenditures necessary for the  
5 Department of Public Health to provide the delivery of  
6 timely newborn screening services in accordance with the  
7 Newborn ~~Metabolic~~ Screening Act.

8 (17) Procurement expenditures necessary for the  
9 Department of Agriculture, the Department of Financial and  
10 Professional Regulation, the Department of Human Services,  
11 and the Department of Public Health to implement the  
12 Compassionate Use of Medical Cannabis Program and Opioid  
13 Alternative Pilot Program requirements and ensure access  
14 to medical cannabis for patients with debilitating medical  
15 conditions in accordance with the Compassionate Use of  
16 Medical Cannabis Program Act.

17 (18) This Code does not apply to any procurements  
18 necessary for the Department of Agriculture, the  
19 Department of Financial and Professional Regulation, the  
20 Department of Human Services, the Department of Commerce  
21 and Economic Opportunity, and the Department of Public  
22 Health to implement the Cannabis Regulation and Tax Act if  
23 the applicable agency has made a good faith determination  
24 that it is necessary and appropriate for the expenditure  
25 to fall within this exemption and if the process is  
26 conducted in a manner substantially in accordance with the

1 requirements of Sections 20-160, 25-60, 30-22, 50-5,  
2 50-10, 50-10.5, 50-12, 50-13, 50-15, 50-20, 50-21, 50-35,  
3 50-36, 50-37, 50-38, and 50-50 of this Code; however, for  
4 Section 50-35, compliance applies only to contracts or  
5 subcontracts over \$100,000. Notice of each contract  
6 entered into under this paragraph (18) that is related to  
7 the procurement of goods and services identified in  
8 paragraph (1) through (9) of this subsection shall be  
9 published in the Procurement Bulletin within 14 calendar  
10 days after contract execution. The Chief Procurement  
11 Officer shall prescribe the form and content of the  
12 notice. Each agency shall provide the Chief Procurement  
13 Officer, on a monthly basis, in the form and content  
14 prescribed by the Chief Procurement Officer, a report of  
15 contracts that are related to the procurement of goods and  
16 services identified in this subsection. At a minimum, this  
17 report shall include the name of the contractor, a  
18 description of the supply or service provided, the total  
19 amount of the contract, the term of the contract, and the  
20 exception to this Code utilized. A copy of any or all of  
21 these contracts shall be made available to the Chief  
22 Procurement Officer immediately upon request. The Chief  
23 Procurement Officer shall submit a report to the Governor  
24 and General Assembly no later than November 1 of each year  
25 that includes, at a minimum, an annual summary of the  
26 monthly information reported to the Chief Procurement

1       Officer. This exemption becomes inoperative 5 years after  
2       June 25, 2019 (the effective date of Public Act 101-27).

3       (19) Acquisition of modifications or adjustments,  
4       limited to assistive technology devices and assistive  
5       technology services, adaptive equipment, repairs, and  
6       replacement parts to provide reasonable accommodations (i)  
7       that enable a qualified applicant with a disability to  
8       complete the job application process and be considered for  
9       the position such qualified applicant desires, (ii) that  
10      modify or adjust the work environment to enable a  
11      qualified current employee with a disability to perform  
12      the essential functions of the position held by that  
13      employee, (iii) to enable a qualified current employee  
14      with a disability to enjoy equal benefits and privileges  
15      of employment as are enjoyed by other similarly situated  
16      employees without disabilities, and (iv) that allow a  
17      customer, client, claimant, or member of the public  
18      seeking State services full use and enjoyment of and  
19      access to its programs, services, or benefits.

20       For purposes of this paragraph (19):

21       "Assistive technology devices" means any item, piece  
22      of equipment, or product system, whether acquired  
23      commercially off the shelf, modified, or customized, that  
24      is used to increase, maintain, or improve functional  
25      capabilities of individuals with disabilities.

26       "Assistive technology services" means any service that

1 directly assists an individual with a disability in  
2 selection, acquisition, or use of an assistive technology  
3 device.

4 "Qualified" has the same meaning and use as provided  
5 under the federal Americans with Disabilities Act when  
6 describing an individual with a disability.

7 (20) Procurement expenditures necessary for the  
8 Illinois Commerce Commission to hire third-party  
9 facilitators pursuant to Sections 16-105.17 and 16-108.18  
10 of the Public Utilities Act or an ombudsman pursuant to  
11 Section 16-107.5 of the Public Utilities Act, a  
12 facilitator pursuant to Section 16-105.17 of the Public  
13 Utilities Act, or a grid auditor pursuant to Section  
14 16-105.10 of the Public Utilities Act.

15 (21) Procurement expenditures for the purchase,  
16 renewal, and expansion of software, software licenses, or  
17 software maintenance agreements that support the efforts  
18 of the Illinois State Police to enforce, regulate, and  
19 administer the Firearm Owners Identification Card Act, the  
20 Firearm Concealed Carry Act, the Firearms Restraining  
21 Order Act, the Firearm Dealer License Certification Act,  
22 the Law Enforcement Agencies Data System (LEADS), the  
23 Uniform Crime Reporting Act, the Criminal Identification  
24 Act, the Illinois Uniform Conviction Information Act, and  
25 the Gun Trafficking Information Act, or establish or  
26 maintain record management systems necessary to conduct

1 human trafficking investigations or gun trafficking or  
2 other stolen firearm investigations. This paragraph (21)  
3 applies to contracts entered into on or after January 10,  
4 2023 (the effective date of Public Act 102-1116) and the  
5 renewal of contracts that are in effect on January 10,  
6 2023 (the effective date of Public Act 102-1116).

7 (22) Contracts for project management services and  
8 system integration services required for the completion of  
9 the State's enterprise resource planning project. This  
10 exemption becomes inoperative 5 years after June 7, 2023  
11 (the effective date of the changes made to this Section by  
12 Public Act 103-8). This paragraph (22) applies to  
13 contracts entered into on or after June 7, 2023 (the  
14 effective date of the changes made to this Section by  
15 Public Act 103-8) and the renewal of contracts that are in  
16 effect on June 7, 2023 (the effective date of the changes  
17 made to this Section by Public Act 103-8).

18 (23) Procurements necessary for the Department of  
19 Insurance to implement the Illinois Health Benefits  
20 Exchange Law if the Department of Insurance has made a  
21 good faith determination that it is necessary and  
22 appropriate for the expenditure to fall within this  
23 exemption. The procurement process shall be conducted in a  
24 manner substantially in accordance with the requirements  
25 of Sections 20-160 and 25-60 and Article 50 of this Code. A  
26 copy of these contracts shall be made available to the

1 Chief Procurement Officer immediately upon request. This  
2 paragraph is inoperative 5 years after June 27, 2023 (the  
3 effective date of Public Act 103-103).

4 (24) Contracts for public education programming,  
5 noncommercial sustaining announcements, public service  
6 announcements, and public awareness and education  
7 messaging with the nonprofit trade associations of the  
8 providers of those services that inform the public on  
9 immediate and ongoing health and safety risks and hazards.

10 (25) Procurements necessary for the Department of  
11 Early Childhood to implement the Department of Early  
12 Childhood Act if the Department has made a good faith  
13 determination that it is necessary and appropriate for the  
14 expenditure to fall within this exemption. This exemption  
15 shall only be used for products and services procured  
16 solely for use by the Department of Early Childhood. The  
17 procurements may include those necessary to design and  
18 build integrated, operational systems of programs and  
19 services. The procurements may include, but are not  
20 limited to, those necessary to align and update program  
21 standards, integrate funding systems, design and establish  
22 data and reporting systems, align and update models for  
23 technical assistance and professional development, design  
24 systems to manage grants and ensure compliance, design and  
25 implement management and operational structures, and  
26 establish new means of engaging with families, educators,

1 providers, and stakeholders. The procurement processes  
2 shall be conducted in a manner substantially in accordance  
3 with the requirements of Article 50 (ethics) and Sections  
4 5-5 (Procurement Policy Board), 5-7 (Commission on Equity  
5 and Inclusion), 20-80 (contract files), 20-120  
6 (subcontractors), 20-155 (paperwork), 20-160  
7 (ethics/campaign contribution prohibitions), 25-60  
8 (prevailing wage), and 25-90 (prohibited and authorized  
9 cybersecurity) of this Code. Beginning January 1, 2025,  
10 the Department of Early Childhood shall provide a  
11 quarterly report to the General Assembly detailing a list  
12 of expenditures and contracts for which the Department  
13 uses this exemption. This paragraph is inoperative on and  
14 after July 1, 2027.

15 (26) ~~(25)~~ Procurements that are necessary for  
16 increasing the recruitment and retention of State  
17 employees, particularly minority candidates for  
18 employment, including:

19 (A) procurements related to registration fees for  
20 job fairs and other outreach and recruitment events;

21 (B) production of recruitment materials; and

22 (C) other services related to recruitment and  
23 retention of State employees.

24 The exemption under this paragraph (26) ~~(25)~~ applies  
25 only if the State agency has made a good faith  
26 determination that it is necessary and appropriate for the

1 expenditure to fall within this paragraph (26) ~~(25)~~. The  
2 procurement process under this paragraph (26) ~~(25)~~ shall  
3 be conducted in a manner substantially in accordance with  
4 the requirements of Sections 20-160 and 25-60 and Article  
5 50 of this Code. A copy of these contracts shall be made  
6 available to the Chief Procurement Officer immediately  
7 upon request. Nothing in this paragraph (26) ~~(25)~~  
8 authorizes the replacement or diminishment of State  
9 responsibilities in hiring or the positions that  
10 effectuate that hiring. This paragraph (26) ~~(25)~~ is  
11 inoperative on and after June 30, 2029.

12 Notwithstanding any other provision of law, for contracts  
13 with an annual value of more than \$100,000 entered into on or  
14 after October 1, 2017 under an exemption provided in any  
15 paragraph of this subsection (b), except paragraph (1), (2),  
16 or (5), each State agency shall post to the appropriate  
17 procurement bulletin the name of the contractor, a description  
18 of the supply or service provided, the total amount of the  
19 contract, the term of the contract, and the exception to the  
20 Code utilized. The chief procurement officer shall submit a  
21 report to the Governor and General Assembly no later than  
22 November 1 of each year that shall include, at a minimum, an  
23 annual summary of the monthly information reported to the  
24 chief procurement officer.

25 (c) This Code does not apply to the electric power  
26 procurement process provided for under Section 1-75 of the

1 Illinois Power Agency Act and Section 16-111.5 of the Public  
2 Utilities Act. This Code does not apply to the procurement of  
3 technical and policy experts pursuant to Section 1-129 of the  
4 Illinois Power Agency Act.

5 (d) Except for Section 20-160 and Article 50 of this Code,  
6 and as expressly required by Section 9.1 of the Illinois  
7 Lottery Law, the provisions of this Code do not apply to the  
8 procurement process provided for under Section 9.1 of the  
9 Illinois Lottery Law.

10 (e) This Code does not apply to the process used by the  
11 Capital Development Board to retain a person or entity to  
12 assist the Capital Development Board with its duties related  
13 to the determination of costs of a clean coal SNG brownfield  
14 facility, as defined by Section 1-10 of the Illinois Power  
15 Agency Act, as required in subsection (h-3) of Section 9-220  
16 of the Public Utilities Act, including calculating the range  
17 of capital costs, the range of operating and maintenance  
18 costs, or the sequestration costs or monitoring the  
19 construction of clean coal SNG brownfield facility for the  
20 full duration of construction.

21 (f) (Blank).

22 (g) (Blank).

23 (h) This Code does not apply to the process to procure or  
24 contracts entered into in accordance with Sections 11-5.2 and  
25 11-5.3 of the Illinois Public Aid Code.

26 (i) Each chief procurement officer may access records

1 necessary to review whether a contract, purchase, or other  
2 expenditure is or is not subject to the provisions of this  
3 Code, unless such records would be subject to attorney-client  
4 privilege.

5 (j) This Code does not apply to the process used by the  
6 Capital Development Board to retain an artist or work or works  
7 of art as required in Section 14 of the Capital Development  
8 Board Act.

9 (k) This Code does not apply to the process to procure  
10 contracts, or contracts entered into, by the State Board of  
11 Elections or the State Electoral Board for hearing officers  
12 appointed pursuant to the Election Code.

13 (l) This Code does not apply to the processes used by the  
14 Illinois Student Assistance Commission to procure supplies and  
15 services paid for from the private funds of the Illinois  
16 Prepaid Tuition Fund. As used in this subsection (l), "private  
17 funds" means funds derived from deposits paid into the  
18 Illinois Prepaid Tuition Trust Fund and the earnings thereon.

19 (m) This Code shall apply regardless of the source of  
20 funds with which contracts are paid, including federal  
21 assistance moneys. Except as specifically provided in this  
22 Code, this Code shall not apply to procurement expenditures  
23 necessary for the Department of Public Health to conduct the  
24 Healthy Illinois Survey in accordance with Section 2310-431 of  
25 the Department of Public Health Powers and Duties Law of the  
26 Civil Administrative Code of Illinois.

1 (Source: P.A. 102-175, eff. 7-29-21; 102-483, eff. 1-1-22;  
2 102-558, eff. 8-20-21; 102-600, eff. 8-27-21; 102-662, eff.  
3 9-15-21; 102-721, eff. 1-1-23; 102-813, eff. 5-13-22;  
4 102-1116, eff. 1-10-23; 103-8, eff. 6-7-23; 103-103, eff.  
5 6-27-23; 103-570, eff. 1-1-24; 103-580, eff. 12-8-23; 103-594,  
6 eff. 6-25-24; 103-605, eff. 7-1-24; 103-865, eff. 1-1-25;  
7 revised 11-26-24.)

8 Section 15. The Illinois Public Aid Code is amended by  
9 changing Section 5-5 as follows:

10 (305 ILCS 5/5-5)

11 (Text of Section before amendment by P.A. 103-808)

12 Sec. 5-5. Medical services. The Illinois Department, by  
13 rule, shall determine the quantity and quality of and the rate  
14 of reimbursement for the medical assistance for which payment  
15 will be authorized, and the medical services to be provided,  
16 which may include all or part of the following: (1) inpatient  
17 hospital services; (2) outpatient hospital services; (3) other  
18 laboratory and X-ray services; (4) skilled nursing home  
19 services; (5) physicians' services whether furnished in the  
20 office, the patient's home, a hospital, a skilled nursing  
21 home, or elsewhere; (6) medical care, or any other type of  
22 remedial care furnished by licensed practitioners; (7) home  
23 health care services; (8) private duty nursing service; (9)  
24 clinic services; (10) dental services, including prevention

1 and treatment of periodontal disease and dental caries disease  
2 for pregnant individuals, provided by an individual licensed  
3 to practice dentistry or dental surgery; for purposes of this  
4 item (10), "dental services" means diagnostic, preventive, or  
5 corrective procedures provided by or under the supervision of  
6 a dentist in the practice of his or her profession; (11)  
7 physical therapy and related services; (12) prescribed drugs,  
8 dentures, and prosthetic devices; and eyeglasses prescribed by  
9 a physician skilled in the diseases of the eye, or by an  
10 optometrist, whichever the person may select; (13) other  
11 diagnostic, screening, preventive, and rehabilitative  
12 services, including to ensure that the individual's need for  
13 intervention or treatment of mental disorders or substance use  
14 disorders or co-occurring mental health and substance use  
15 disorders is determined using a uniform screening, assessment,  
16 and evaluation process inclusive of criteria, for children and  
17 adults; for purposes of this item (13), a uniform screening,  
18 assessment, and evaluation process refers to a process that  
19 includes an appropriate evaluation and, as warranted, a  
20 referral; "uniform" does not mean the use of a singular  
21 instrument, tool, or process that all must utilize; (14)  
22 transportation and such other expenses as may be necessary;  
23 (15) medical treatment of sexual assault survivors, as defined  
24 in Section 1a of the Sexual Assault Survivors Emergency  
25 Treatment Act, for injuries sustained as a result of the  
26 sexual assault, including examinations and laboratory tests to

1 discover evidence which may be used in criminal proceedings  
2 arising from the sexual assault; (16) the diagnosis and  
3 treatment of sickle cell anemia; (16.5) services performed by  
4 a chiropractic physician licensed under the Medical Practice  
5 Act of 1987 and acting within the scope of his or her license,  
6 including, but not limited to, chiropractic manipulative  
7 treatment; and (17) any other medical care, and any other type  
8 of remedial care recognized under the laws of this State. The  
9 term "any other type of remedial care" shall include nursing  
10 care and nursing home service for persons who rely on  
11 treatment by spiritual means alone through prayer for healing.

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

19 Notwithstanding any other provision of this Code,  
20 reproductive health care that is otherwise legal in Illinois  
21 shall be covered under the medical assistance program for  
22 persons who are otherwise eligible for medical assistance  
23 under this Article.

24 Notwithstanding any other provision of this Section, all  
25 tobacco cessation medications approved by the United States  
26 Food and Drug Administration and all individual and group

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

21 Notwithstanding any other provision of this Code, the  
22 Illinois Department may not require, as a condition of payment  
23 for any laboratory test authorized under this Article, that a  
24 physician's handwritten signature appear on the laboratory  
25 test order form. The Illinois Department may, however, impose  
26 other appropriate requirements regarding laboratory test order

1 documentation.

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

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

26           (1) dental services provided by or under the

1 supervision of a dentist; and

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

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

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

26 Subject to federal approval, on and after January 1, 2025,

1 the rates paid for sedation evaluation and the provision of  
2 deep sedation and intravenous sedation for the purpose of  
3 dental services shall be increased by 33% above the rates in  
4 effect on December 31, 2024. The rates paid for nitrous oxide  
5 sedation shall not be impacted by this paragraph and shall  
6 remain the same as the rates in effect on December 31, 2024.

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

20 Subject to appropriation and to federal approval, the  
21 Department shall file administrative rules updating the  
22 Handicapping Labio-Lingual Deviation orthodontic scoring tool  
23 by January 1, 2025, or as soon as practicable.

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

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

20 The Illinois Department, by rule, may distinguish and  
21 classify the medical services to be provided only in  
22 accordance with the classes of persons designated in Section  
23 5-2.

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

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

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

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

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

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

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

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

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

18 For purposes of this Section:

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

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

26 "Low-dose mammography" means the x-ray examination of the

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

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

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

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

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

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

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

23      The Department shall convene an expert panel, including  
24      representatives of hospitals, free-standing breast cancer  
25      treatment centers, breast cancer quality organizations, and  
26      doctors, including breast surgeons, reconstructive breast

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

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

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

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

25 The Department shall devise a means of case-managing or  
26 patient navigation for beneficiaries diagnosed with breast

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

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

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

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

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

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

25 All medical providers providing medical assistance to  
26 pregnant individuals under this Code shall receive information

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

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

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

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

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

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

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

26           (2) The Department may elect to consider and negotiate

1 financial incentives to encourage the development of  
2 Partnerships and the efficient delivery of medical care.

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

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

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

25 The Department shall apply for a waiver from the United  
26 States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.

2 The Illinois Department shall require health care  
3 providers to maintain records that document the medical care  
4 and services provided to recipients of Medical Assistance  
5 under this Article. Such records must be retained for a period  
6 of not less than 6 years from the date of service or as  
7 provided by applicable State law, whichever period is longer,  
8 except that if an audit is initiated within the required  
9 retention period then the records must be retained until the  
10 audit is completed and every exception is resolved. The  
11 Illinois Department shall require health care providers to  
12 make available, when authorized by the patient, in writing,  
13 the medical records in a timely fashion to other health care  
14 providers who are treating or serving persons eligible for  
15 Medical Assistance under this Article. All dispensers of  
16 medical services shall be required to maintain and retain  
17 business and professional records sufficient to fully and  
18 accurately document the nature, scope, details and receipt of  
19 the health care provided to persons eligible for medical  
20 assistance under this Code, in accordance with regulations  
21 promulgated by the Illinois Department. The rules and  
22 regulations shall require that proof of the receipt of  
23 prescription drugs, dentures, prosthetic devices and  
24 eyeglasses by eligible persons under this Section accompany  
25 each claim for reimbursement submitted by the dispenser of  
26 such medical services. No such claims for reimbursement shall

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

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

1 acceptance and payment of nursing home claims.

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

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

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

1 regarding medical bills paid by the Illinois Department, which  
2 inquiries could indicate potential existence of claims or  
3 liens for the Illinois Department.

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

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

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

1 screening as required by federal or State law.

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

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

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

24 (2) In the case of errors attributable to the Illinois  
25 Department or any of its claims processing intermediaries  
26 which result in an inability to receive, process, or

1 adjudicate a claim, the 180-day period shall not begin  
2 until the provider has been notified of the error.

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

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

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

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

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

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

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

23 The Illinois Department shall enter into agreements with  
24 State agencies and departments, and is authorized to enter  
25 into agreements with federal agencies and departments, under  
26 which such agencies and departments shall share data necessary

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

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

1 take any action or acquire any products or services.

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

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

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

5 In order to promote environmental responsibility, meet the  
6 needs of recipients and enrollees, and achieve significant  
7 cost savings, the Department, or a managed care organization  
8 under contract with the Department, may provide recipients or  
9 managed care enrollees who have a prescription or Certificate  
10 of Medical Necessity access to refurbished durable medical  
11 equipment under this Section (excluding prosthetic and  
12 orthotic devices as defined in the Orthotics, Prosthetics, and  
13 Pedorthics Practice Act and complex rehabilitation technology  
14 products and associated services) through the State's  
15 assistive technology program's reutilization program, using  
16 staff with the Assistive Technology Professional (ATP)  
17 Certification if the refurbished durable medical equipment:  
18 (i) is available; (ii) is less expensive, including shipping  
19 costs, than new durable medical equipment of the same type;  
20 (iii) is able to withstand at least 3 years of use; (iv) is  
21 cleaned, disinfected, sterilized, and safe in accordance with  
22 federal Food and Drug Administration regulations and guidance  
23 governing the reprocessing of medical devices in health care  
24 settings; and (v) equally meets the needs of the recipient or  
25 enrollee. The reutilization program shall confirm that the  
26 recipient or enrollee is not already in receipt of the same or

1 similar equipment from another service provider, and that the  
2 refurbished durable medical equipment equally meets the needs  
3 of the recipient or enrollee. Nothing in this paragraph shall  
4 be construed to limit recipient or enrollee choice to obtain  
5 new durable medical equipment or place any additional prior  
6 authorization conditions on enrollees of managed care  
7 organizations.

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

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

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

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

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

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

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

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

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

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

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

26 Because kidney transplantation can be an appropriate,

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

16 Notwithstanding any other provision of this Code to the  
17 contrary, on or after July 1, 2015, all FDA-approved ~~FDA~~  
18 ~~approved~~ forms of medication assisted treatment prescribed for  
19 the treatment of alcohol dependence or treatment of opioid  
20 dependence shall be covered under both fee-for-service and  
21 managed care medical assistance programs for persons who are  
22 otherwise eligible for medical assistance under this Article  
23 and shall not be subject to any (1) utilization control, other  
24 than those established under the American Society of Addiction  
25 Medicine patient placement criteria, (2) prior authorization  
26 mandate, (3) lifetime restriction limit mandate, or (4)

1 limitations on dosage.

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

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

1 individuals who are not infected with HIV but who are at high  
2 risk of HIV infection.

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

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

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

1 subject to criteria established in accordance with all  
2 applicable laws.

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

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

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

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

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

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

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

1 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article  
2 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,  
3 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;  
4 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.  
5 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;  
6 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.  
7 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;  
8 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.  
9 1-1-24; 103-593, Article 5, Section 5-5, eff. 6-7-24; 103-593,  
10 Article 90, Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24;  
11 103-909, eff. 8-9-24; 103-1040, eff. 8-9-24; revised  
12 10-10-24.)

13 (Text of Section after amendment by P.A. 103-808)

14 Sec. 5-5. Medical services. The Illinois Department, by  
15 rule, shall determine the quantity and quality of and the rate  
16 of reimbursement for the medical assistance for which payment  
17 will be authorized, and the medical services to be provided,  
18 which may include all or part of the following: (1) inpatient  
19 hospital services; (2) outpatient hospital services; (3) other  
20 laboratory and X-ray services; (4) skilled nursing home  
21 services; (5) physicians' services whether furnished in the  
22 office, the patient's home, a hospital, a skilled nursing  
23 home, or elsewhere; (6) medical care, or any other type of  
24 remedial care furnished by licensed practitioners; (7) home  
25 health care services; (8) private duty nursing service; (9)

1 clinic services; (10) dental services, including prevention  
2 and treatment of periodontal disease and dental caries disease  
3 for pregnant individuals, provided by an individual licensed  
4 to practice dentistry or dental surgery; for purposes of this  
5 item (10), "dental services" means diagnostic, preventive, or  
6 corrective procedures provided by or under the supervision of  
7 a dentist in the practice of his or her profession; (11)  
8 physical therapy and related services; (12) prescribed drugs,  
9 dentures, and prosthetic devices; and eyeglasses prescribed by  
10 a physician skilled in the diseases of the eye, or by an  
11 optometrist, whichever the person may select; (13) other  
12 diagnostic, screening, preventive, and rehabilitative  
13 services, including to ensure that the individual's need for  
14 intervention or treatment of mental disorders or substance use  
15 disorders or co-occurring mental health and substance use  
16 disorders is determined using a uniform screening, assessment,  
17 and evaluation process inclusive of criteria, for children and  
18 adults; for purposes of this item (13), a uniform screening,  
19 assessment, and evaluation process refers to a process that  
20 includes an appropriate evaluation and, as warranted, a  
21 referral; "uniform" does not mean the use of a singular  
22 instrument, tool, or process that all must utilize; (14)  
23 transportation and such other expenses as may be necessary;  
24 (15) medical treatment of sexual assault survivors, as defined  
25 in Section 1a of the Sexual Assault Survivors Emergency  
26 Treatment Act, for injuries sustained as a result of the

1 sexual assault, including examinations and laboratory tests to  
2 discover evidence which may be used in criminal proceedings  
3 arising from the sexual assault; (16) the diagnosis and  
4 treatment of sickle cell anemia; (16.5) services performed by  
5 a chiropractic physician licensed under the Medical Practice  
6 Act of 1987 and acting within the scope of his or her license,  
7 including, but not limited to, chiropractic manipulative  
8 treatment; and (17) any other medical care, and any other type  
9 of remedial care recognized under the laws of this State. The  
10 term "any other type of remedial care" shall include nursing  
11 care and nursing home service for persons who rely on  
12 treatment by spiritual means alone through prayer for healing.

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

20 Notwithstanding any other provision of this Code,  
21 reproductive health care that is otherwise legal in Illinois  
22 shall be covered under the medical assistance program for  
23 persons who are otherwise eligible for medical assistance  
24 under this Article.

25 Notwithstanding any other provision of this Section, all  
26 tobacco cessation medications approved by the United States

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

22 Notwithstanding any other provision of this Code, the  
23 Illinois Department may not require, as a condition of payment  
24 for any laboratory test authorized under this Article, that a  
25 physician's handwritten signature appear on the laboratory  
26 test order form. The Illinois Department may, however, impose

1 other appropriate requirements regarding laboratory test order  
2 documentation.

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

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

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

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

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

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

1           Subject to federal approval, on and after January 1, 2025,  
2           the rates paid for sedation evaluation and the provision of  
3           deep sedation and intravenous sedation for the purpose of  
4           dental services shall be increased by 33% above the rates in  
5           effect on December 31, 2024. The rates paid for nitrous oxide  
6           sedation shall not be impacted by this paragraph and shall  
7           remain the same as the rates in effect on December 31, 2024.

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

21          Subject to appropriation and to federal approval, the  
22          Department shall file administrative rules updating the  
23          Handicapping Labio-Lingual Deviation orthodontic scoring tool  
24          by January 1, 2025, or as soon as practicable.

25          On and after January 1, 2022, the Department of Healthcare  
26          and Family Services shall administer and regulate a

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

21 The Illinois Department, by rule, may distinguish and  
22 classify the medical services to be provided only in  
23 accordance with the classes of persons designated in Section  
24 5-2.

25 The Department of Healthcare and Family Services must  
26 provide coverage and reimbursement for amino acid-based

1 elemental formulas, regardless of delivery method, for the  
2 diagnosis and treatment of (i) eosinophilic disorders and (ii)  
3 short bowel syndrome when the prescribing physician has issued  
4 a written order stating that the amino acid-based elemental  
5 formula is medically necessary.

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

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

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

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

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

26 (E) A screening MRI when medically necessary, as

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

3 (F) A diagnostic mammogram when medically necessary,  
4 as determined by a physician licensed to practice medicine  
5 in all its branches, advanced practice registered nurse,  
6 or physician assistant.

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

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

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

25 For purposes of this Section:

26 "Diagnostic mammogram" means a mammogram obtained using

1 diagnostic mammography.

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

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

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

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

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

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

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

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

24 On and after January 1, 2017, providers participating in a  
25 breast cancer treatment quality improvement program approved  
26 by the Department shall be reimbursed for breast cancer

1 treatment at a rate that is no lower than 95% of the Medicare  
2 program's rates for the data elements included in the breast  
3 cancer treatment quality program.

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

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

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

1 evaluation.

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

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

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

1 access for patients diagnosed with cancer to at least one  
2 academic commission on cancer-accredited cancer program as an  
3 in-network covered benefit.

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

15 On or after July 1, 2022, individuals who are otherwise  
16 eligible for medical assistance under this Article shall  
17 receive coverage for perinatal depression screenings for the  
18 12-month period beginning on the last day of their pregnancy.  
19 Medical assistance coverage under this paragraph shall be  
20 conditioned on the use of a screening instrument approved by  
21 the Department.

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

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

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

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

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

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

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

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

1 medical services delivered by Partnership providers to clients  
2 in target areas according to provisions of this Article and  
3 the Illinois Health Finance Reform Act, except that:

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

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

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

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

25 Nothing in this Section shall limit the free choice of  
26 practitioners, hospitals, and other providers of medical

1 services by clients. In order to ensure patient freedom of  
2 choice, the Illinois Department shall immediately promulgate  
3 all rules and take all other necessary actions so that  
4 provided services may be accessed from therapeutically  
5 certified optometrists to the full extent of the Illinois  
6 Optometric Practice Act of 1987 without discriminating between  
7 service providers.

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

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

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

26 Notwithstanding any other law to the contrary, the

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

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

22 The Illinois Department shall require all dispensers of  
23 medical services, other than an individual practitioner or  
24 group of practitioners, desiring to participate in the Medical  
25 Assistance program established under this Article to disclose  
26 all financial, beneficial, ownership, equity, surety or other

1 interests in any and all firms, corporations, partnerships,  
2 associations, business enterprises, joint ventures, agencies,  
3 institutions or other legal entities providing any form of  
4 health care services in this State under this Article.

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

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

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

25 Prior to enrollment and during the conditional enrollment  
26 period in the medical assistance program, all vendors shall be

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

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

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

1 exceptions:

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

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

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

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

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

25 In the case of long term care facilities, within 120  
26 calendar days of receipt by the facility of required

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

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

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

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

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

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

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

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

1 the Department may, by rule, exempt certain replacement  
2 wheelchair parts from prior approval and, for wheelchairs,  
3 wheelchair parts, wheelchair accessories, and related seating  
4 and positioning items, determine the wholesale price by  
5 methods other than actual acquisition costs.

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

14 In order to promote environmental responsibility, meet the  
15 needs of recipients and enrollees, and achieve significant  
16 cost savings, the Department, or a managed care organization  
17 under contract with the Department, may provide recipients or  
18 managed care enrollees who have a prescription or Certificate  
19 of Medical Necessity access to refurbished durable medical  
20 equipment under this Section (excluding prosthetic and  
21 orthotic devices as defined in the Orthotics, Prosthetics, and  
22 Podiatric Practice Act and complex rehabilitation technology  
23 products and associated services) through the State's  
24 assistive technology program's reutilization program, using  
25 staff with the Assistive Technology Professional (ATP)  
26 Certification if the refurbished durable medical equipment:

1 (i) is available; (ii) is less expensive, including shipping  
2 costs, than new durable medical equipment of the same type;  
3 (iii) is able to withstand at least 3 years of use; (iv) is  
4 cleaned, disinfected, sterilized, and safe in accordance with  
5 federal Food and Drug Administration regulations and guidance  
6 governing the reprocessing of medical devices in health care  
7 settings; and (v) equally meets the needs of the recipient or  
8 enrollee. The reutilization program shall confirm that the  
9 recipient or enrollee is not already in receipt of the same or  
10 similar equipment from another service provider, and that the  
11 refurbished durable medical equipment equally meets the needs  
12 of the recipient or enrollee. Nothing in this paragraph shall  
13 be construed to limit recipient or enrollee choice to obtain  
14 new durable medical equipment or place any additional prior  
15 authorization conditions on enrollees of managed care  
16 organizations.

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

1 increase in the determination of need (DON) scores from 29 to  
2 37 for applicants for institutional and home and  
3 community-based long term care; if and only if federal  
4 approval is not granted, the Department may, in conjunction  
5 with other affected agencies, implement utilization controls  
6 or changes in benefit packages to effectuate a similar savings  
7 amount for this population; and (iv) no later than July 1,  
8 2013, minimum level of care eligibility criteria for  
9 institutional and home and community-based long term care; and  
10 (v) no later than October 1, 2013, establish procedures to  
11 permit long term care providers access to eligibility scores  
12 for individuals with an admission date who are seeking or  
13 receiving services from the long term care provider. In order  
14 to select the minimum level of care eligibility criteria, the  
15 Governor shall establish a workgroup that includes affected  
16 agency representatives and stakeholders representing the  
17 institutional and home and community-based long term care  
18 interests. This Section shall not restrict the Department from  
19 implementing lower level of care eligibility criteria for  
20 community-based services in circumstances where federal  
21 approval has been granted.

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

1 services and facilities, as it affects persons eligible for  
2 medical assistance under this Code.

3 The Illinois Department shall report annually to the  
4 General Assembly, no later than the second Friday in April of  
5 1979 and each year thereafter, in regard to:

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

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

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

12 (d) efforts at utilization review and control by the  
13 Illinois Department.

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

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

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

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

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

25 Notwithstanding any other provision of this Code to the  
26 contrary, on or after July 1, 2015, all FDA-approved ~~FDA~~

1 ~~approved~~ forms of medication assisted treatment prescribed for  
2 the treatment of alcohol dependence or treatment of opioid  
3 dependence shall be covered under both fee-for-service and  
4 managed care medical assistance programs for persons who are  
5 otherwise eligible for medical assistance under this Article  
6 and shall not be subject to any (1) utilization control, other  
7 than those established under the American Society of Addiction  
8 Medicine patient placement criteria, (2) prior authorization  
9 mandate, (3) lifetime restriction limit mandate, or (4)  
10 limitations on dosage.

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

26 Upon federal approval, the Department shall provide

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

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

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

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

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

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

1       Notwithstanding any other provision of this Code, the  
2       medical assistance program shall, subject to federal approval,  
3       reimburse hospitals for costs associated with a newborn  
4       screening test for the presence of metachromatic  
5       leukodystrophy, as required under the Newborn ~~Metabolic~~  
6       Screening Act, at a rate not less than the fee charged by the  
7       Department of Public Health. Notwithstanding any other  
8       provision of this Code, the medical assistance program shall,  
9       subject to appropriation and federal approval, also reimburse  
10      hospitals for costs associated with all newborn screening  
11      tests added on and after August 9, 2024 (the effective date of  
12      Public Act 103-909) ~~this amendatory Act of the 103rd General~~  
13      ~~Assembly~~ to the Newborn ~~Metabolic~~ Screening Act and required  
14      to be performed under that Act at a rate not less than the fee  
15      charged by the Department of Public Health. The Department  
16      shall seek federal approval before the implementation of the  
17      newborn screening test fees by the Department of Public  
18      Health.

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

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

9       (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;  
10      102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article  
11      55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,  
12      eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;  
13      102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.  
14      5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;  
15      102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.  
16      1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;  
17      103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.  
18      1-1-24; 103-593, Article 5, Section 5-5, eff. 6-7-24; 103-593,  
19      Article 90, Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24;  
20      103-808, eff. 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff.  
21      8-9-24; revised 10-10-24.)

22       Section 20. The Newborn Metabolic Screening Act is amended  
23       by changing the title of the Act and Sections 0.01 and 2 as  
24       follows:

1 (410 ILCS 240/Act title)

2 An Act concerning health ~~the disease of phenylketonuria~~  
3 ~~and other metabolic diseases, designating certain powers and~~  
4 ~~duties in relation thereto, providing penalties for violation~~  
5 ~~thereof, to repeal an Act therein named and to make an~~  
6 ~~appropriation in connection therewith.~~

7 (410 ILCS 240/0.01) (from Ch. 111 1/2, par. 4902.9)

8 Sec. 0.01. Short title. This Act may be cited as the  
9 Newborn ~~Metabolic~~ Screening Act.

10 (Source: P.A. 95-695, eff. 11-5-07.)

11 (410 ILCS 240/2) (from Ch. 111 1/2, par. 4904)

12 Sec. 2. General provisions. The Department of Public  
13 Health shall administer the provisions of this Act and shall:

14 (a) Institute and carry on an intensive educational  
15 program among physicians, hospitals, public health nurses and  
16 the public concerning disorders included in newborn screening.  
17 This educational program shall include information about the  
18 nature of the diseases and examinations for the detection of  
19 the diseases in early infancy in order that measures may be  
20 taken to prevent the disabilities resulting from the diseases.

21 (a-5) Require that all newborns be screened for the  
22 presence of certain genetic, metabolic, and congenital  
23 anomalies, including hearing disorders, as determined by the  
24 Department, by rule.

1 (a-5.1) Require that all blood and biological specimens  
2 collected pursuant to this Act or the rules adopted under this  
3 Act be submitted for testing to the nearest Department  
4 laboratory designated to perform such tests. The following  
5 provisions shall apply concerning testing:

6 (1) Beginning July 1, 2015, the base fee for newborn  
7 screening services shall be \$118. Beginning July 1, 2026,  
8 the base fee for newborn screening services shall be \$165.  
9 The amount of 22% of the base fee must be allocated to the  
10 Department for the Early Hearing Detection and  
11 Intervention Program. The Department may develop a  
12 reasonable fee structure and may levy additional fees  
13 according to such structure to cover the cost of providing  
14 these ~~this~~ testing services ~~service~~ and for the follow-up  
15 of infants with an abnormal screening test; however,  
16 additional fees may be levied no sooner than 6 months  
17 prior to the beginning of testing for a new genetic,  
18 metabolic, or congenital disorder. Fees collected from the  
19 provision of this testing service shall be placed in the  
20 Metabolic Screening and Treatment Fund. Other State and  
21 federal funds for expenses related to metabolic, hearing,  
22 or congenital disorder screening, follow-up, and treatment  
23 programs may also be placed in the Fund.

24 (2) Moneys shall be appropriated from the Fund to the  
25 Department solely for the purposes of providing newborn  
26 screening, follow-up, and treatment programs. Nothing in

1       this Act shall be construed to prohibit any licensed  
2       medical facility from collecting additional specimens for  
3       testing for metabolic or neonatal diseases or any other  
4       diseases or conditions, as it deems fit. Any person  
5       violating the provisions of this subsection (a-5.1) is  
6       guilty of a petty offense.

7       (3) If the Department is unable to provide the  
8       screening using the State Laboratory, it shall temporarily  
9       provide such screening through an accredited laboratory  
10      selected by the Department until the Department has the  
11      capacity to provide screening through the State  
12      Laboratory. If screening is provided on a temporary basis  
13      through an accredited laboratory, the Department shall  
14      substitute the fee charged by the accredited laboratory,  
15      plus a 5% surcharge for documentation and handling, for  
16      the fee authorized in this subsection (a-5.1). This  
17      paragraph (3) does not apply to hearing screenings.

18      (a-5.2) Maintain a registry of cases, including  
19      information of importance for the purpose of follow-up  
20      services to assess long-term outcomes.

21      (a-5.3) Supply the necessary metabolic treatment formulas  
22      where practicable for diagnosed cases of amino acid metabolism  
23      disorders, including phenylketonuria, organic acid disorders,  
24      and fatty acid oxidation disorders for as long as medically  
25      indicated, when the product is not available through other  
26      State agencies.

1 (a-5.4) Arrange for or provide public health nursing,  
2 nutrition, and social services and clinical consultation as  
3 indicated.

4 (a-5.5) Utilize the Genetic and Metabolic Diseases  
5 Advisory Committee established under the Genetic and Metabolic  
6 Diseases Advisory Committee Act to provide guidance and  
7 recommendations to the Department's newborn screening program.  
8 The Genetic and Metabolic Diseases Advisory Committee shall  
9 review the feasibility and advisability of including  
10 additional metabolic, genetic, and congenital disorders in the  
11 newborn screening panel, according to a review protocol  
12 applied to each suggested addition to the screening panel. The  
13 Department shall consider the recommendations of the Genetic  
14 and Metabolic Diseases Advisory Committee in determining  
15 whether to include an additional disorder in the screening  
16 panel prior to proposing an administrative rule concerning  
17 inclusion of an additional disorder in the newborn screening  
18 panel. This subsection (a-5.5) does not apply to hearing  
19 screenings. Notwithstanding any other provision of law, no new  
20 screening may begin prior to the occurrence of all the  
21 following:

22 (1) the establishment and verification of relevant and  
23 appropriate performance specifications as defined under  
24 the federal Clinical Laboratory Improvement Amendments and  
25 regulations thereunder for U.S. Food and Drug  
26 Administration-cleared or in-house developed methods,

1 performed under an institutional review board-approved  
2 protocol, if required;

3 (2) the availability of quality assurance testing  
4 methodology for the processes set forth in item (1) of  
5 this subsection (a-5.5);

6 (3) the acquisition and installment by the Department  
7 of the equipment necessary to implement the screening  
8 tests;

9 (4) the establishment of precise threshold values  
10 ensuring defined disorder identification for each  
11 screening test;

12 (5) the authentication of pilot testing achieving each  
13 milestone described in items (1) through (4) of this  
14 subsection (a-5.5) for each disorder screening test; and

15 (6) the authentication of achieving the potential of  
16 high throughput standards for statewide volume of each  
17 disorder screening test concomitant with each milestone  
18 described in items (1) through (4) of this subsection  
19 (a-5.5).

20 (a-6) (Blank).

21 (a-7) (Blank).

22 (a-8) (Blank).

23 (b) (Blank).

24 (c) (Blank).

25 (d) (Blank).

26 (e) (Blank).

1 (Source: P.A. 98-440, eff. 8-16-13; 98-756, eff. 7-16-14;  
2 99-403, eff. 8-19-15.)

3 Section 25. The Genetic Information Privacy Act is amended  
4 by changing Section 30 as follows:

5 (410 ILCS 513/30)

6 Sec. 30. Disclosure of person tested and test results.

7 (a) No person may disclose or be compelled to disclose the  
8 identity of any person upon whom a genetic test is performed or  
9 the results of a genetic test in a manner that permits  
10 identification of the subject of the test, except to the  
11 following persons:

12 (1) The subject of the test or the subject's legally  
13 authorized representative. This paragraph does not create  
14 a duty or obligation under which a health care provider  
15 must notify the subject's spouse or legal guardian of the  
16 test results, and no such duty or obligation shall be  
17 implied. No civil liability or criminal sanction under  
18 this Act shall be imposed for any disclosure or  
19 nondisclosure of a test result to a spouse by a physician  
20 acting in good faith under this paragraph. For the purpose  
21 of any proceedings, civil or criminal, the good faith of  
22 any physician acting under this paragraph shall be  
23 presumed.

24 (2) Any person designated in a specific written

1       legally effective authorization for release of the test  
2       results executed by the subject of the test or the  
3       subject's legally authorized representative.

4           (3) An authorized agent or employee of a health  
5       facility or health care provider if the health facility or  
6       health care provider itself is authorized to obtain the  
7       test results, the agent or employee provides patient care,  
8       and the agent or employee has a need to know the  
9       information in order to conduct the tests or provide care  
10      or treatment.

11          (4) A health facility, health care provider, or health  
12      care professional that procures, processes, distributes,  
13      or uses:

14           (A) a human body part from a deceased person with  
15      respect to medical information regarding that person;  
16      or

17           (B) semen provided prior to the effective date of  
18      this Act for the purpose of artificial insemination.

19          (5) Health facility staff committees for the purposes  
20      of conducting program monitoring, program evaluation, or  
21      service reviews.

22          (6) In the case of a minor under 18 years of age, the  
23      health care provider, health care professional, or health  
24      facility who ordered the test shall make a reasonable  
25      effort to notify the minor's parent or legal guardian if,  
26      in the professional judgment of the health care provider,

1 health care professional, or health facility, notification  
2 would be in the best interest of the minor and the health  
3 care provider, health care professional, or health  
4 facility has first sought unsuccessfully to persuade the  
5 minor to notify the parent or legal guardian or after a  
6 reasonable time after the minor has agreed to notify the  
7 parent or legal guardian, the health care provider, health  
8 care professional, or health facility has reason to  
9 believe that the minor has not made the notification. This  
10 paragraph shall not create a duty or obligation under  
11 which a health care provider, health care professional, or  
12 health facility must notify the minor's parent or legal  
13 guardian of the test results, nor shall a duty or  
14 obligation be implied. No civil liability or criminal  
15 sanction under this Act shall be imposed for any  
16 notification or non-notification of a minor's test result  
17 by a health care provider, health care professional, or  
18 health facility acting in good faith under this paragraph.  
19 For the purpose of any proceeding, civil or criminal, the  
20 good faith of any health care provider, health care  
21 professional, or health facility acting under this  
22 paragraph shall be presumed.

23 (b) All information and records held by a State agency,  
24 local health authority, or health oversight agency pertaining  
25 to genetic information shall be strictly confidential and  
26 exempt from copying and inspection under the Freedom of

1 Information Act. The information and records shall not be  
2 released or made public by the State agency, local health  
3 authority, or health oversight agency and shall not be  
4 admissible as evidence nor discoverable in any action of any  
5 kind in any court or before any tribunal, board, agency, or  
6 person and shall be treated in the same manner as the  
7 information and those records subject to the provisions of  
8 Part 21 of Article VIII of the Code of Civil Procedure except  
9 under the following circumstances:

10 (A) when made with the written consent of all  
11 persons to whom the information pertains;

12 (B) when authorized by Section 5-4-3 of the  
13 Unified Code of Corrections;

14 (C) when made for the sole purpose of implementing  
15 the Newborn ~~Metabolic~~ Screening Act and rules; or

16 (D) when made under the authorization of the  
17 Illinois Parentage Act of 2015.

18 Disclosure shall be limited to those who have a need to  
19 know the information, and no additional disclosures may be  
20 made.

21 (c) Disclosure by an insurer in accordance with the  
22 requirements of the Article XL of the Illinois Insurance Code  
23 shall be deemed compliance with this Section.

24 (Source: P.A. 98-1046, eff. 1-1-15; 99-85, eff. 1-1-16.)

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

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

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