



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB4393

Introduced 1/14/2026, by Rep. Joyce Mason

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that on and after January 1, 2027, the rates paid for children's dental comprehensive oral exams, periodic oral exams, problem focused exams, behavior management codes, sealants, resin-based composites-posterior teeth, and extraction and surgical extraction codes shall be increased by 33% above the rates in effect on December 31, 2025. Effective January 1, 2027.

LRB104 16875 KTG 30285 b

1 AN ACT concerning public aid.

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

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

6 (305 ILCS 5/5-5)

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

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

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

1 a chiropractic physician licensed under the Medical Practice
2 Act of 1987 and acting within the scope of his or her license,
3 including, but not limited to, chiropractic manipulative
4 treatment; and (17) any other medical care, and any other type
5 of remedial care recognized under the laws of this State. The
6 term "any other type of remedial care" shall include nursing
7 care and nursing home service for persons who rely on
8 treatment by spiritual means alone through prayer for healing.

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

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

21 Notwithstanding any other provision of this Section, all
22 tobacco cessation medications approved by the United States
23 Food and Drug Administration and all individual and group
24 tobacco cessation counseling services and telephone-based
25 counseling services and tobacco cessation medications provided
26 through the Illinois Tobacco Quitline shall be covered under

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

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

25 Upon receipt of federal approval of an amendment to the
26 Illinois Title XIX State Plan for this purpose, the Department

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

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

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

25 (2) eyeglasses prescribed by a physician skilled in
26 the diseases of the eye, or by an optometrist, whichever

1 the person may select.

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

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

23 Subject to federal approval, on and after January 1, 2025,
24 the rates paid for sedation evaluation and the provision of
25 deep sedation and intravenous sedation for the purpose of
26 dental services shall be increased by 33% above the rates in

1 effect on December 31, 2024. The rates paid for nitrous oxide
2 sedation shall not be impacted by this paragraph and shall
3 remain the same as the rates in effect on December 31, 2024.

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

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

21 On and after January 1, 2022, the Department of Healthcare
22 and Family Services shall administer and regulate a
23 school-based dental program that allows for the out-of-office
24 delivery of preventative dental services in a school setting
25 to children under 19 years of age. The Department shall
26 establish, by rule, guidelines for participation by providers

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

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

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

1 formula is medically necessary.

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

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

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

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

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

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

25 (F) A diagnostic mammogram when medically necessary,
26 as determined by a physician licensed to practice medicine

1 in all its branches, advanced practice registered nurse,
2 or physician assistant.

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

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

15 For purposes of this Section:

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

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

23 "Low-dose mammography" means the x-ray examination of the
24 breast using equipment dedicated specifically for mammography,
25 including the x-ray tube, filter, compression device, and
26 image receptor, with an average radiation exposure delivery of

1 less than one rad per breast for 2 views of an average size
2 breast. The term also includes digital mammography and
3 includes breast tomosynthesis.

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

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

24 On and after January 1, 2016, the Department shall ensure
25 that all networks of care for adult clients of the Department
26 include access to at least one breast imaging Center of

1 Imaging Excellence as certified by the American College of
2 Radiology.

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

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

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

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

26 Subject to federal approval, the Department shall

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

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

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

22 The Department shall devise a means of case-managing or
23 patient navigation for beneficiaries diagnosed with breast
24 cancer. This program shall initially operate as a pilot
25 program in areas of the State with the highest incidence of
26 mortality related to breast cancer. At least one pilot program

1 site shall be in the metropolitan Chicago area and at least one
2 site shall be outside the metropolitan Chicago area. On or
3 after July 1, 2016, the pilot program shall be expanded to
4 include one site in western Illinois, one site in southern
5 Illinois, one site in central Illinois, and 4 sites within
6 metropolitan Chicago. An evaluation of the pilot program shall
7 be carried out measuring health outcomes and cost of care for
8 those served by the pilot program compared to similarly
9 situated patients who are not served by the pilot program.

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

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

1 preauthorization requirements for the administration of the
2 human papillomavirus (HPV) vaccine.

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

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

22 All medical providers providing medical assistance to
23 pregnant individuals under this Code shall receive information
24 from the Department on the availability of services under any
25 program providing case management services for addicted
26 individuals, including information on appropriate referrals

1 for other social services that may be needed by addicted
2 individuals in addition to treatment for addiction.

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

11 Neither the Department of Healthcare and Family Services
12 nor the Department of Human Services shall sanction the
13 recipient solely on the basis of the recipient's substance
14 abuse.

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

24 The Illinois Department may develop and contract with
25 Partnerships of medical providers to arrange medical services
26 for persons eligible under Section 5-2 of this Code.

1 Implementation of this Section may be by demonstration
2 projects in certain geographic areas. The Partnership shall be
3 represented by a sponsor organization. The Department, by
4 rule, shall develop qualifications for sponsors of
5 Partnerships. Nothing in this Section shall be construed to
6 require that the sponsor organization be a medical
7 organization.

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

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

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

26 (3) Persons receiving medical services through

1 Partnerships may receive medical and case management
2 services above the level usually offered through the
3 medical assistance program.

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

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

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

25 The Illinois Department shall require health care
26 providers to maintain records that document the medical care

1 and services provided to recipients of Medical Assistance
2 under this Article. Such records must be retained for a period
3 of not less than 6 years from the date of service or as
4 provided by applicable State law, whichever period is longer,
5 except that if an audit is initiated within the required
6 retention period then the records must be retained until the
7 audit is completed and every exception is resolved. The
8 Illinois Department shall require health care providers to
9 make available, when authorized by the patient, in writing,
10 the medical records in a timely fashion to other health care
11 providers who are treating or serving persons eligible for
12 Medical Assistance under this Article. All dispensers of
13 medical services shall be required to maintain and retain
14 business and professional records sufficient to fully and
15 accurately document the nature, scope, details and receipt of
16 the health care provided to persons eligible for medical
17 assistance under this Code, in accordance with regulations
18 promulgated by the Illinois Department. The rules and
19 regulations shall require that proof of the receipt of
20 prescription drugs, dentures, prosthetic devices and
21 eyeglasses by eligible persons under this Section accompany
22 each claim for reimbursement submitted by the dispenser of
23 such medical services. No such claims for reimbursement shall
24 be approved for payment by the Illinois Department without
25 such proof of receipt, unless the Illinois Department shall
26 have put into effect and shall be operating a system of

1 post-payment audit and review which shall, on a sampling
2 basis, be deemed adequate by the Illinois Department to assure
3 that such drugs, dentures, prosthetic devices and eyeglasses
4 for which payment is being made are actually being received by
5 eligible recipients. Within 90 days after September 16, 1984
6 (the effective date of Public Act 83-1439), the Illinois
7 Department shall establish a current list of acquisition costs
8 for all prosthetic devices and any other items recognized as
9 medical equipment and supplies reimbursable under this Article
10 and shall update such list on a quarterly basis, except that
11 the acquisition costs of all prescription drugs shall be
12 updated no less frequently than every 30 days as required by
13 Section 5-5.12.

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

25 Notwithstanding any other law to the contrary, the
26 Illinois Department shall, within 365 days after August 15,

1 2014 (the effective date of Public Act 98-963), establish
2 procedures to permit ID/DD facilities licensed under the ID/DD
3 Community Care Act and MC/DD facilities licensed under the
4 MC/DD Act to submit monthly billing claims for reimbursement
5 purposes. Following development of these procedures, the
6 Department shall have an additional 365 days to test the
7 viability of the new system and to ensure that any necessary
8 operational or structural changes to its information
9 technology platforms are implemented.

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

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

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

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

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

25 The Department shall define or specify the following: (i)
26 by provider notice, the "category of risk of the vendor" for

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

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

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

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

26 (3) In the case of a provider for whom the Illinois

1 Department initiates the monthly billing process.

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

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

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

1 the admission transaction has been completed.

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

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

20 The Illinois Department shall enter into agreements with
21 State agencies and departments, and is authorized to enter
22 into agreements with federal agencies and departments, under
23 which such agencies and departments shall share data necessary
24 for medical assistance program integrity functions and
25 oversight. The Illinois Department shall develop, in
26 cooperation with other State departments and agencies, and in

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

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

25 The Illinois Department shall establish policies,
26 procedures, standards and criteria by rule for the

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

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

1 must meet the accreditation requirement.

2 In order to promote environmental responsibility, meet the
3 needs of recipients and enrollees, and achieve significant
4 cost savings, the Department, or a managed care organization
5 under contract with the Department, may provide recipients or
6 managed care enrollees who have a prescription or Certificate
7 of Medical Necessity access to refurbished durable medical
8 equipment under this Section (excluding prosthetic and
9 orthotic devices as defined in the Orthotics, Prosthetics, and
10 Pedorthics Practice Act and complex rehabilitation technology
11 products and associated services) through the State's
12 assistive technology program's reutilization program, using
13 staff with the Assistive Technology Professional (ATP)
14 Certification if the refurbished durable medical equipment:
15 (i) is available; (ii) is less expensive, including shipping
16 costs, than new durable medical equipment of the same type;
17 (iii) is able to withstand at least 3 years of use; (iv) is
18 cleaned, disinfected, sterilized, and safe in accordance with
19 federal Food and Drug Administration regulations and guidance
20 governing the reprocessing of medical devices in health care
21 settings; and (v) equally meets the needs of the recipient or
22 enrollee. The reutilization program shall confirm that the
23 recipient or enrollee is not already in receipt of the same or
24 similar equipment from another service provider, and that the
25 refurbished durable medical equipment equally meets the needs
26 of the recipient or enrollee. Nothing in this paragraph shall

1 be construed to limit recipient or enrollee choice to obtain
2 new durable medical equipment or place any additional prior
3 authorization conditions on enrollees of managed care
4 organizations.

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

1 receiving services from the long term care provider. In order
2 to select the minimum level of care eligibility criteria, the
3 Governor shall establish a workgroup that includes affected
4 agency representatives and stakeholders representing the
5 institutional and home and community-based long term care
6 interests. This Section shall not restrict the Department from
7 implementing lower level of care eligibility criteria for
8 community-based services in circumstances where federal
9 approval has been granted.

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

17 The Illinois Department shall report annually to the
18 General Assembly, no later than the second Friday in April of
19 1979 and each year thereafter, in regard to:

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

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

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

26 (d) efforts at utilization review and control by the

1 Illinois Department.

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

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

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

23 Because kidney transplantation can be an appropriate,
24 cost-effective alternative to renal dialysis when medically
25 necessary and notwithstanding the provisions of Section 1-11
26 of this Code, beginning October 1, 2014, the Department shall

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

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

25 On or after July 1, 2015, opioid antagonists prescribed
26 for the treatment of an opioid overdose, including the

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

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

26 A federally qualified health center, as defined in Section

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

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

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

26 Notwithstanding any other provision of this Code,

1 community-based pediatric palliative care from a trained
2 interdisciplinary team shall be covered under the medical
3 assistance program as provided in Section 15 of the Pediatric
4 Palliative Care Act.

5 Notwithstanding any other provision of this Code, within
6 12 months after June 2, 2022 (the effective date of Public Act
7 102-1037) and subject to federal approval, acupuncture
8 services performed by an acupuncturist licensed under the
9 Acupuncture Practice Act who is acting within the scope of his
10 or her license shall be covered under the medical assistance
11 program. The Department shall apply for any federal waiver or
12 State Plan amendment, if required, to implement this
13 paragraph. The Department may adopt any rules, including
14 standards and criteria, necessary to implement this paragraph.

15 Notwithstanding any other provision of this Code, the
16 medical assistance program shall, subject to federal approval,
17 reimburse hospitals for costs associated with a newborn
18 screening test for the presence of metachromatic
19 leukodystrophy, as required under the Newborn Metabolic
20 Screening Act, at a rate not less than the fee charged by the
21 Department of Public Health. Notwithstanding any other
22 provision of this Code, the medical assistance program shall,
23 subject to appropriation and federal approval, also reimburse
24 hospitals for costs associated with all newborn screening
25 tests added on and after August 9, 2024 (the effective date of
26 Public Act 103-909) to the Newborn Metabolic Screening Act and

1 required to be performed under that Act at a rate not less than
2 the fee charged by the Department of Public Health. The
3 Department shall seek federal approval before the
4 implementation of the newborn screening test fees by the
5 Department of Public Health.

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

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

22 Subject to federal approval, for dates of services on and
23 after January 1, 2026, over-the-counter choline dietary
24 supplements for pregnant persons shall be covered under the
25 medical assistance program.

26 (Source: P.A. 103-102, Article 15, Section 15-5, eff. 1-1-24;

1 103-102, Article 95, Section 95-15, eff. 1-1-24; 103-123, eff.
2 1-1-24; 103-154, eff. 6-30-23; 103-368, eff. 1-1-24; 103-593,
3 Article 5, Section 5-5, eff. 6-7-24; 103-593, Article 90,
4 Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24; 103-909, eff.
5 8-9-24; 103-1040, eff. 8-9-24; 104-9, eff. 6-16-25; 104-417,
6 eff. 8-15-25.)

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

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

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

1 including, but not limited to, chiropractic manipulative
2 treatment; and (17) any other medical care, and any other type
3 of remedial care recognized under the laws of this State. The
4 term "any other type of remedial care" shall include nursing
5 care and nursing home service for persons who rely on
6 treatment by spiritual means alone through prayer for healing.

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

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

19 Notwithstanding any other provision of this Section, all
20 tobacco cessation medications approved by the United States
21 Food and Drug Administration and all individual and group
22 tobacco cessation counseling services and telephone-based
23 counseling services and tobacco cessation medications provided
24 through the Illinois Tobacco Quitline shall be covered under
25 the medical assistance program for persons who are otherwise
26 eligible for assistance under this Article. The Department

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

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

23 Upon receipt of federal approval of an amendment to the
24 Illinois Title XIX State Plan for this purpose, the Department
25 shall authorize the Chicago Public Schools (CPS) to procure a
26 vendor or vendors to manufacture eyeglasses for individuals

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

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

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

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

26 On and after July 1, 2018, the Department of Healthcare

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

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

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

1 remain the same as the rates in effect on December 31, 2024.

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

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

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

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

15 On and after January 1, 2027, the rates paid for
16 children's dental comprehensive oral exams, periodic oral
17 exams, problem focused exams, behavior management codes,
18 sealants, resin-based composites-posterior teeth, and
19 extraction and surgical extraction codes shall be increased by
20 33% above the rates in effect on December 31, 2025.

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 breast imaging technologies, breast surgeons,
9 reconstructive breast surgeons, oncologists, and primary care
10 providers to establish quality standards for breast cancer
11 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 Pedorthics 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 forms of

1 medication assisted treatment prescribed for the treatment of
2 alcohol dependence or treatment of opioid dependence shall be
3 covered under both fee-for-service and managed care medical
4 assistance programs for persons who are otherwise eligible for
5 medical assistance under this Article and shall not be subject
6 to any (1) utilization control, other than those established
7 under the American Society of Addiction Medicine patient
8 placement criteria, (2) prior authorization mandate, (3)
9 lifetime restriction limit mandate, or (4) limitations on
10 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) to the Newborn Metabolic Screening Act and
13 required to be performed under that Act at a rate not less than
14 the fee charged by the Department of Public Health. The
15 Department shall seek federal approval before the
16 implementation of the newborn screening test fees by the
17 Department of Public Health.

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

26 Notwithstanding any other provision of this Code,

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

8 Subject to federal approval, for dates of services on and
9 after January 1, 2026, over-the-counter choline dietary
10 supplements for pregnant persons shall be covered under the
11 medical assistance program.

12 (Source: P.A. 103-102, Article 15, Section 15-5, eff. 1-1-24;
13 103-102, Article 95, Section 95-15, eff. 1-1-24; 103-123, eff.
14 1-1-24; 103-154, eff. 6-30-23; 103-368, eff. 1-1-24; 103-593,
15 Article 5, Section 5-5, eff. 6-7-24; 103-593, Article 90,
16 Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24; 103-808, eff.
17 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff. 8-9-24; 104-9,
18 eff. 6-16-25; 104-417, eff. 8-15-25.)

19 Section 95. No acceleration or delay. Where this Act makes
20 changes in a statute that is represented in this Act by text
21 that is not yet or no longer in effect (for example, a Section
22 represented by multiple versions), the use of that text does
23 not accelerate or delay the taking effect of (i) the changes
24 made by this Act or (ii) provisions derived from any other
25 Public Act.

1 Section 99. Effective date. This Act takes effect January
2 1, 2027.