



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB4932

by Rep. Amy Elik

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 reimbursement rates for all orthodontic services for children shall be increased 50% above the rates in effect on December 31, 2026. Requires the Department of Healthcare and Family Services to do an evaluation of the network adequacy of Medicaid providers of orthodontic services statewide, and give priority consideration to rural/Downstate areas of the State. Effective January 1, 2027.

LRB104 19771 KTG 33221 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 Sec. 5-5. Medical services. The Illinois Department, by
8 rule, shall determine the quantity and quality of and the rate
9 of reimbursement for the medical assistance for which payment
10 will be authorized, and the medical services to be provided,
11 which may include all or part of the following: (1) inpatient
12 hospital services; (2) outpatient hospital services; (3) other
13 laboratory and X-ray services; (4) skilled nursing home
14 services; (5) physicians' services whether furnished in the
15 office, the patient's home, a hospital, a skilled nursing
16 home, or elsewhere; (6) medical care, or any other type of
17 remedial care furnished by licensed practitioners; (7) home
18 health care services; (8) private duty nursing service; (9)
19 clinic services; (10) dental services, including prevention
20 and treatment of periodontal disease and dental caries disease
21 for pregnant individuals, provided by an individual licensed
22 to practice dentistry or dental surgery; for purposes of this
23 item (10), "dental services" means diagnostic, preventive, or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Subject to federal approval, on and after January 1, 2025,
23 the rates paid for sedation evaluation and the provision of
24 deep sedation and intravenous sedation for the purpose of
25 dental services shall be increased by 33% above the rates in
26 effect on December 31, 2024. The rates paid for nitrous oxide

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

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

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

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

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

16 On and after January 1, 2027, the reimbursement rates for
17 all orthodontic services for children shall be increased 50%
18 above the rates in effect on December 31, 2026. The Department
19 must do an evaluation of the network adequacy of Medicaid
20 providers of orthodontic services statewide, and shall give
21 priority consideration to rural/Downstate areas of the State.

22 The Illinois Department, by rule, may distinguish and
23 classify the medical services to be provided only in
24 accordance with the classes of persons designated in Section
25 5-2.

26 The Department of Healthcare and Family Services must

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

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

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

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

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

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

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

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

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

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

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

26 For purposes of this Section:

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

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

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

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

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

1 18031(d)(3)(B) or any successor provision, to defray the cost
2 of any coverage for breast tomosynthesis outlined in this
3 paragraph, then the requirement that an insurer cover breast
4 tomosynthesis is inoperative other than any such coverage
5 authorized under Section 1902 of the Social Security Act, 42
6 U.S.C. 1396a, and the State shall not assume any obligation
7 for the cost of coverage for breast tomosynthesis set forth in
8 this paragraph.

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

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

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

25 On and after January 1, 2017, providers participating in a
26 breast cancer treatment quality improvement program approved

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

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

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

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

1 their effectiveness and modifying the methodology based on the
2 evaluation.

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

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

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

1 Department shall require all networks of care to include
2 access for patients diagnosed with cancer to at least one
3 academic commission on cancer-accredited cancer program as an
4 in-network covered benefit.

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

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

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

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

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

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

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

1 abuse.

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

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

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

1 obstetrical care. The Illinois Department shall reimburse
2 medical services delivered by Partnership providers to clients
3 in target areas according to provisions of this Article and
4 the Illinois Health Finance Reform Act, except that:

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

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

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

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

26 Nothing in this Section shall limit the free choice of

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

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

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

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

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

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

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

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

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

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

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

26 Prior to enrollment and during the conditional enrollment

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

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

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

1 medical goods or services were provided, with the following
2 exceptions:

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

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

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

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

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

26 In the case of long term care facilities, within 120

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 and programs for monitoring of utilization of health care
2 services and facilities, as it affects persons eligible for
3 medical assistance under this Code.

4 The Illinois Department shall report annually to the
5 General Assembly, no later than the second Friday in April of
6 1979 and each year thereafter, in regard to:

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

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

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

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

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

25 Rulemaking authority to implement Public Act 95-1045, if
26 any, is conditioned on the rules being adopted in accordance

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

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

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

26 Notwithstanding any other provision of this Code to the

1 contrary, on or after July 1, 2015, all FDA-approved forms of
2 medication assisted treatment prescribed for the treatment of
3 alcohol dependence or treatment of opioid dependence shall be
4 covered under both fee-for-service and managed care medical
5 assistance programs for persons who are otherwise eligible for
6 medical assistance under this Article and shall not be subject
7 to any (1) utilization control, other than those established
8 under the American Society of Addiction Medicine patient
9 placement criteria, (2) prior authorization mandate, (3)
10 lifetime restriction limit mandate, or (4) limitations on
11 dosage.

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

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

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

21 Within 90 days after October 8, 2021 (the effective date
22 of Public Act 102-665), the Department shall seek federal
23 approval of a State Plan amendment to expand coverage for
24 family planning services that includes presumptive eligibility
25 to individuals whose income is at or below 208% of the federal
26 poverty level. Coverage under this Section shall be effective

1 beginning no later than December 1, 2022.

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

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

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

1 standards and criteria, necessary to implement this paragraph.

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

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

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

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

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

20 Section 99. Effective date. This Act takes effect January
21 1, 2027.