



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB5451

Introduced 2/13/2026, by Rep. Mary Beth Canty

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to authorize coverage for screening by low-dose mammography for the presence of occult breast cancer for individuals 25 (rather than 35) years of age or older who are otherwise eligible for medical assistance. Requires the Department to convene 2 separate expert panels to review quality standards for mammography and establish quality standards for breast cancer treatment. Provides that subject to Department approval, rate methodology for screening and diagnostic mammography shall be based on the quality standards established by the expert panels and State qualified ACR Designated Comprehensive Breast Imaging Centers (formerly known as Breast Imaging Centers of Excellence). Requires the expert panels to establish a comprehensive and clinical methodology to inform women who are age-appropriate for screening mammography, but who have not received a mammogram within the previous 18 months, of the importance and benefits of screening mammography. Provides that within 2 years after the completion of a pilot program providing case-managing or patient navigation services for women diagnosed with breast cancer, the Department shall establish as a permanent initiative the Patient Assistance for Beneficiaries Diagnosed with Breast Cancer. Requires the Department to submit annual reports to the General Assembly detailing program outcomes, financial expenditures, and any recommendations for adjustments to maintain or enhance the program's effectiveness. Requires the Department to establish or facilitate training and continuing education opportunities specific to breast health and mammography for radiologists. Makes other changes. Effective immediately.

LRB104 18569 KTG 32012 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 The Illinois Department, by rule, may distinguish and
17 classify the medical services to be provided only in
18 accordance with the classes of persons designated in Section
19 5-2.

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

1 The Illinois Department shall authorize the provision of,
2 and shall authorize payment for, screening by low-dose
3 mammography for the presence of occult breast cancer for
4 individuals 25 ~~35~~ years of age or older who are eligible for
5 medical assistance under this Article, as follows:

6 (A) A baseline mammogram for individuals 25 ~~35~~ to 39
7 years of age.

8 (B) An annual mammogram for individuals 40 years of
9 age or older with no family history.

10 (C) A mammogram at the age and intervals considered
11 medically necessary by the individual's health care
12 provider for individuals under 40 years of age, based on
13 physician recommendation for familial risk, ~~and having a~~
14 family history of breast cancer, prior personal history of
15 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 (G) Molecular breast imaging (MBI) and MRI of an
4 entire breast or breasts if a mammogram demonstrates
5 heterogeneous or dense breast tissue or when medically
6 necessary as determined by a physician licensed to
7 practice medicine in all of its branches, advanced
8 practice registered nurse, or physician assistant.

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

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

21 For purposes of this Section:

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

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

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

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

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

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

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

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

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

16 The Department shall convene an expert panel of not more
17 than 15 members that includes ~~including~~ representatives of
18 hospitals, free-standing mammography facilities, and doctors,
19 including radiologists, to review ~~establish~~ quality standards
20 for mammography. The panel shall be convened no later than
21 January 1, 2027, meet quarterly thereafter, and act as an
22 advisory body for developing quality standards for
23 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. This panel shall be in place by no later than
12 January 1, 2027, and meet at least quarterly thereafter either
13 in person or via remote teleconference.

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

21 Subject to Department approval, the rate methodology for
22 screening and diagnostic mammography shall be based on the
23 quality standards established by the 2 expert panels convened
24 by the Department and State qualified ACR Designated
25 Comprehensive Breast Imaging Centers (formerly known as Breast
26 Imaging Centers of Excellence). These centers or clinics may

1 also collaborate with other hospital-based mammography
2 facilities. By April 1, 2027, the Department shall submit to
3 the General Assembly a progress report on the implementation
4 of this paragraph.

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

14 The expert panels convened by the Department shall also
15 establish a comprehensive and clinical methodology to inform
16 women who are age-appropriate for screening mammography, but
17 who have not received a mammogram within the previous 18
18 months, of the importance and benefits of screening
19 mammography. The Department shall work with an independent,
20 nonprofit organization with a demonstrated history of
21 coordinating and facilitating access to breast cancer
22 screening and diagnostic services across multiple mammography
23 facilities or units. The organization must not be a hospital
24 or directly affiliated entity, and must not receive Medicaid
25 reimbursement for breast cancer screening and diagnostic
26 services across multiple mammography facilities or units. The

1 organization shall provide navigation, outreach, and support
2 services specifically for uninsured or underinsured
3 individuals in the designated area and maintain active
4 collaborations with a network of community-based mammography
5 providers. The organization shall optimize reminders on breast
6 cancer outreach and patient navigation, and shall establish a
7 methodology for evaluating their effectiveness and modifying
8 the methodology based on the evaluation.

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

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

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

3 Upon the successful completion and evaluation of the pilot
4 program, the Patient Assistance for Beneficiaries Diagnosed
5 with Breast Cancer shall be established as a permanent
6 initiative, effective within 2 years of the evaluation's
7 completion. Beginning in the fiscal year immediately following
8 the program's permanent establishment, the initiative shall,
9 subject to appropriation, receive full funding to ensure that
10 resources are allocated to support its operational and
11 programmatic needs. The Department shall, on or before
12 November 1 of that first fiscal year, and every November 1
13 thereafter, submit a report to the General Assembly detailing
14 program outcomes, financial expenditures, and any
15 recommendations for adjustments to maintain or enhance the
16 program's effectiveness.

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

25 The Department shall establish or facilitate training and
26 continuing education opportunities specific to breast health

1 and mammography for radiologists, ensuring that these
2 professionals are equipped with the latest knowledge and
3 skills to accurately diagnose and assess breast cancer.
4 Similar training and continuing education opportunities shall
5 be provided for mammography technologists to ensure
6 consistent, high-quality imaging practices that support early
7 detection and accurate diagnosis.

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

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

26 The Department shall establish a grant program to assist

1 safety net facilities in acquiring or upgrading mammography
2 equipment to support equitable access to state-of-the-art
3 diagnostic tools. The grant program shall also, subject to
4 appropriation, include funding for the hiring of qualified
5 navigation staff, development of outreach initiatives tailored
6 to high-risk populations, and ongoing program evaluation to
7 ensure that navigation services effectively connect patients
8 with needed care.

9 Safety net facilities shall have access to free resources
10 for enhancing their quality of care, including, but not
11 limited to, staff training programs, financial support to
12 subsidize or incorporate a comprehensive mammography database,
13 and other essential quality-improvement initiatives.

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

26 All medical providers providing medical assistance to

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

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

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

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

1 procedures to the Illinois Department.

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

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

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

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

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

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

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

26 The Department shall apply for a waiver from the United

1 States Health Care Financing Administration to allow for the
2 implementation of Partnerships under this Section.

3 The Illinois Department shall require health care
4 providers to maintain records that document the medical care
5 and services provided to recipients of Medical Assistance
6 under this Article. Such records must be retained for a period
7 of not less than 6 years from the date of service or as
8 provided by applicable State law, whichever period is longer,
9 except that if an audit is initiated within the required
10 retention period then the records must be retained until the
11 audit is completed and every exception is resolved. The
12 Illinois Department shall require health care providers to
13 make available, when authorized by the patient, in writing,
14 the medical records in a timely fashion to other health care
15 providers who are treating or serving persons eligible for
16 Medical Assistance under this Article. All dispensers of
17 medical services shall be required to maintain and retain
18 business and professional records sufficient to fully and
19 accurately document the nature, scope, details and receipt of
20 the health care provided to persons eligible for medical
21 assistance under this Code, in accordance with regulations
22 promulgated by the Illinois Department. The rules and
23 regulations shall require that proof of the receipt of
24 prescription drugs, dentures, prosthetic devices and
25 eyeglasses by eligible persons under this Section accompany
26 each claim for reimbursement submitted by the dispenser of

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

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

1 technology platforms in order to allow for the direct
2 acceptance and payment of nursing home claims.

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

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

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

1 by rule establish, all inquiries from clients and attorneys
2 regarding medical bills paid by the Illinois Department, which
3 inquiries could indicate potential existence of claims or
4 liens for the Illinois Department.

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

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

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

1 reviews; audits; payment caps; payment suspensions; and other
2 screening as required by federal or State law.

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

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

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

25 (2) In the case of errors attributable to the Illinois
26 Department or any of its claims processing intermediaries

1 which result in an inability to receive, process, or
2 adjudicate a claim, the 180-day period shall not begin
3 until the provider has been notified of the error.

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

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

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

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

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

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

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

24 The Illinois Department shall enter into agreements with
25 State agencies and departments, and is authorized to enter
26 into agreements with federal agencies and departments, under

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

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

1 or as an obligation on the part of the Illinois Department to
2 take any action or acquire any products or services.

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

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

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

6 In order to promote environmental responsibility, meet the
7 needs of recipients and enrollees, and achieve significant
8 cost savings, the Department, or a managed care organization
9 under contract with the Department, may provide recipients or
10 managed care enrollees who have a prescription or Certificate
11 of Medical Necessity access to refurbished durable medical
12 equipment under this Section (excluding prosthetic and
13 orthotic devices as defined in the Orthotics, Prosthetics, and
14 Pedorthics Practice Act and complex rehabilitation technology
15 products and associated services) through the State's
16 assistive technology program's reutilization program, using
17 staff with the Assistive Technology Professional (ATP)
18 Certification if the refurbished durable medical equipment:
19 (i) is available; (ii) is less expensive, including shipping
20 costs, than new durable medical equipment of the same type;
21 (iii) is able to withstand at least 3 years of use; (iv) is
22 cleaned, disinfected, sterilized, and safe in accordance with
23 federal Food and Drug Administration regulations and guidance
24 governing the reprocessing of medical devices in health care
25 settings; and (v) equally meets the needs of the recipient or
26 enrollee. The reutilization program shall confirm that the

1 recipient or enrollee is not already in receipt of the same or
2 similar equipment from another service provider, and that the
3 refurbished durable medical equipment equally meets the needs
4 of the recipient or enrollee. Nothing in this paragraph shall
5 be construed to limit recipient or enrollee choice to obtain
6 new durable medical equipment or place any additional prior
7 authorization conditions on enrollees of managed care
8 organizations.

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

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

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

21 The Illinois Department shall report annually to the
22 General Assembly, no later than the second Friday in April of
23 1979 and each year thereafter, in regard to:

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

26 (b) actual statistics and trends in the provision of

1 the various medical services by medical vendors;

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

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

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

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

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

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

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

1 lifetime restriction limit mandate, or (4) limitations on
2 dosage.

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

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

1 counseling to reduce the likelihood of HIV infection among
2 individuals who are not infected with HIV but who are at high
3 risk of HIV infection.

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

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

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

1 become a covered benefit of the medical assistance program,
2 subject to criteria established in accordance with all
3 applicable laws.

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

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

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

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

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

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

26 Subject to federal approval, for dates of services on and

1 after January 1, 2026, over-the-counter choline dietary
2 supplements for pregnant persons shall be covered under the
3 medical assistance program.

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

11 Section 99. Effective date. This Act takes effect upon
12 becoming law.