

# SB0206



## 104TH GENERAL ASSEMBLY

### State of Illinois

2025 and 2026

SB0206

Introduced 1/22/2025, by Sen. Doris Turner

#### SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that hypoallergenic formula shall be covered under the medical assistance program for persons otherwise eligible for medical assistance who have been prescribed hypoallergenic formula by a physician. Requires the Department of Healthcare and Family Services to apply for any federal waivers or approvals necessary to implement the amendatory Act. Provides that upon federal approval, the Department shall at a minimum determine by rule the amount of hypoallergenic formula an eligible person shall receive coverage for per day.

LRB104 08790 KTG 18845 b

A BILL FOR

1 AN ACT concerning public aid.

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

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

6 (305 ILCS 5/5-5)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the person may select.

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

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

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

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

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

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

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

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

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

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

1 formula is medically necessary.

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

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

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

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

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

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

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

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

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

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

15 For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

26 Subject to federal approval, the Department shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (3) Persons receiving medical services through

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Department initiates the monthly billing process.

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

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

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

1 the admission transaction has been completed.

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

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

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

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

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

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

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

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

1 must meet the accreditation requirement.

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

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

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

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

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

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

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

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

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

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

1 Illinois Department.

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

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

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

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

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

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

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

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

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

26 A federally qualified health center, as defined in Section

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

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

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

26 Notwithstanding any other provision of this Code,

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

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

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

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

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

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

23 Notwithstanding any other provision of this Code,  
24 hypoallergenic formula shall be covered under the medical  
25 assistance program for persons otherwise eligible for medical  
26 assistance who have been prescribed hypoallergenic formula by

1 a physician. The Department shall apply for any federal  
2 waivers or approvals necessary to implement this paragraph.  
3 Upon federal approval, the Department shall at a minimum  
4 determine by rule the amount of hypoallergenic formula an  
5 eligible person shall receive coverage for per day.

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

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

20 Sec. 5-5. Medical services. The Illinois Department, by  
21 rule, shall determine the quantity and quality of and the rate  
22 of reimbursement for the medical assistance for which payment  
23 will be authorized, and the medical services to be provided,  
24 which may include all or part of the following: (1) inpatient  
25 hospital services; (2) outpatient hospital services; (3) other

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

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

19 Notwithstanding any other provision of this Section, a  
20 comprehensive tobacco use cessation program that includes  
21 purchasing prescription drugs or prescription medical devices  
22 approved by the Food and Drug Administration shall be covered  
23 under the medical assistance program under this Article for  
24 persons who are otherwise eligible for assistance under this  
25 Article.

26 Notwithstanding any other provision of this Code,

1 reproductive health care that is otherwise legal in Illinois  
2 shall be covered under the medical assistance program for  
3 persons who are otherwise eligible for medical assistance  
4 under this Article.

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

1 approval.

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

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

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

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

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

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

23           On and after July 1, 2018, targeted dental services, as  
24 set forth in Exhibit D of the Consent Decree entered by the  
25 United States District Court for the Northern District of  
26 Illinois, Eastern Division, in the matter of Memisovski v.

1 Maram, Case No. 92 C 1982, that are provided to adults under  
2 the medical assistance program shall be established at no less  
3 than the rates set forth in the "New Rate" column in Exhibit D  
4 of the Consent Decree for targeted dental services that are  
5 provided to persons under the age of 18 under the medical  
6 assistance program.

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

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

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

5           On and after January 1, 2022, the Department of Healthcare  
6 and Family Services shall administer and regulate a  
7 school-based dental program that allows for the out-of-office  
8 delivery of preventative dental services in a school setting  
9 to children under 19 years of age. The Department shall  
10 establish, by rule, guidelines for participation by providers  
11 and set requirements for follow-up referral care based on the  
12 requirements established in the Dental Office Reference Manual  
13 published by the Department that establishes the requirements  
14 for dentists participating in the All Kids Dental School  
15 Program. Every effort shall be made by the Department when  
16 developing the program requirements to consider the different  
17 geographic differences of both urban and rural areas of the  
18 State for initial treatment and necessary follow-up care. No  
19 provider shall be charged a fee by any unit of local government  
20 to participate in the school-based dental program administered  
21 by the Department. Nothing in this paragraph shall be  
22 construed to limit or preempt a home rule unit's or school  
23 district's authority to establish, change, or administer a  
24 school-based dental program in addition to, or independent of,  
25 the school-based dental program administered by the  
26 Department.

1           The Illinois Department, by rule, may distinguish and  
2           classify the medical services to be provided only in  
3           accordance with the classes of persons designated in Section  
4           5-2.

5           The Department of Healthcare and Family Services must  
6           provide coverage and reimbursement for amino acid-based  
7           elemental formulas, regardless of delivery method, for the  
8           diagnosis and treatment of (i) eosinophilic disorders and (ii)  
9           short bowel syndrome when the prescribing physician has issued  
10          a written order stating that the amino acid-based elemental  
11          formula is medically necessary.

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

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

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

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

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

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

9           (F) A diagnostic mammogram when medically necessary,  
10          as determined by a physician licensed to practice medicine  
11          in all its branches, advanced practice registered nurse,  
12          or physician assistant.

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

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

1 All screenings shall include a physical breast exam,  
2 instruction on self-examination and information regarding the  
3 frequency of self-examination and its value as a preventative  
4 tool.

5 For purposes of this Section:

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

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

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

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

24 If, at any time, the Secretary of the United States  
25 Department of Health and Human Services, or its successor  
26 agency, promulgates rules or regulations to be published in

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

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

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

26 The Department shall convene an expert panel including

1 representatives of hospitals, free-standing mammography  
2 facilities, and doctors, including radiologists, to establish  
3 quality standards for mammography.

4 On and after January 1, 2017, providers participating in a  
5 breast cancer treatment quality improvement program approved  
6 by the Department shall be reimbursed for breast cancer  
7 treatment at a rate that is no lower than 95% of the Medicare  
8 program's rates for the data elements included in the breast  
9 cancer treatment quality program.

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

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

25 The Department shall establish a methodology to remind  
26 individuals who are age-appropriate for screening mammography,

1 but who have not received a mammogram within the previous 18  
2 months, of the importance and benefit of screening  
3 mammography. The Department shall work with experts in breast  
4 cancer outreach and patient navigation to optimize these  
5 reminders and shall establish a methodology for evaluating  
6 their effectiveness and modifying the methodology based on the  
7 evaluation.

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

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

1 situated patients who are not served by the pilot program.

2 The Department shall require all networks of care to  
3 develop a means either internally or by contract with experts  
4 in navigation and community outreach to navigate cancer  
5 patients to comprehensive care in a timely fashion. The  
6 Department shall require all networks of care to include  
7 access for patients diagnosed with cancer to at least one  
8 academic commission on cancer-accredited cancer program as an  
9 in-network covered benefit.

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

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

1 the Department.

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

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

21 The Illinois Department, in cooperation with the  
22 Departments of Human Services (as successor to the Department  
23 of Alcoholism and Substance Abuse) and Public Health, through  
24 a public awareness campaign, may provide information  
25 concerning treatment for alcoholism and drug abuse and  
26 addiction, prenatal health care, and other pertinent programs

1 directed at reducing the number of drug-affected infants born  
2 to recipients of medical assistance.

3 Neither the Department of Healthcare and Family Services  
4 nor the Department of Human Services shall sanction the  
5 recipient solely on the basis of the recipient's substance  
6 abuse.

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

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

26 The sponsor must negotiate formal written contracts with

1 medical providers for physician services, inpatient and  
2 outpatient hospital care, home health services, treatment for  
3 alcoholism and substance abuse, and other services determined  
4 necessary by the Illinois Department by rule for delivery by  
5 Partnerships. Physician services must include prenatal and  
6 obstetrical care. The Illinois Department shall reimburse  
7 medical services delivered by Partnership providers to clients  
8 in target areas according to provisions of this Article and  
9 the Illinois Health Finance Reform Act, except that:

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

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

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

22 Medical providers shall be required to meet certain  
23 qualifications to participate in Partnerships to ensure the  
24 delivery of high quality medical services. These  
25 qualifications shall be determined by rule of the Illinois  
26 Department and may be higher than qualifications for

1 participation in the medical assistance program. Partnership  
2 sponsors may prescribe reasonable additional qualifications  
3 for participation by medical providers, only with the prior  
4 written approval of the Illinois Department.

5 Nothing in this Section shall limit the free choice of  
6 practitioners, hospitals, and other providers of medical  
7 services by clients. In order to ensure patient freedom of  
8 choice, the Illinois Department shall immediately promulgate  
9 all rules and take all other necessary actions so that  
10 provided services may be accessed from therapeutically  
11 certified optometrists to the full extent of the Illinois  
12 Optometric Practice Act of 1987 without discriminating between  
13 service providers.

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

17 The Illinois Department shall require health care  
18 providers to maintain records that document the medical care  
19 and services provided to recipients of Medical Assistance  
20 under this Article. Such records must be retained for a period  
21 of not less than 6 years from the date of service or as  
22 provided by applicable State law, whichever period is longer,  
23 except that if an audit is initiated within the required  
24 retention period then the records must be retained until the  
25 audit is completed and every exception is resolved. The  
26 Illinois Department shall require health care providers to

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

1 medical equipment and supplies reimbursable under this Article  
2 and shall update such list on a quarterly basis, except that  
3 the acquisition costs of all prescription drugs shall be  
4 updated no less frequently than every 30 days as required by  
5 Section 5-5.12.

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

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

1 technology platforms are implemented.

2 The Illinois Department shall require all dispensers of  
3 medical services, other than an individual practitioner or  
4 group of practitioners, desiring to participate in the Medical  
5 Assistance program established under this Article to disclose  
6 all financial, beneficial, ownership, equity, surety or other  
7 interests in any and all firms, corporations, partnerships,  
8 associations, business enterprises, joint ventures, agencies,  
9 institutions or other legal entities providing any form of  
10 health care services in this State under this Article.

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

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

1 penalty.

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

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

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

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

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

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

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

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

24 For claims for services rendered during a period for which  
25 a recipient received retroactive eligibility, claims must be  
26 filed within 180 days after the Department determines the

1 applicant is eligible. For claims for which the Illinois  
2 Department is not the primary payer, claims must be submitted  
3 to the Illinois Department within 180 days after the final  
4 adjudication by the primary payer.

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

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

24 To the extent consistent with applicable information and  
25 privacy, security, and disclosure laws, State and federal  
26 agencies and departments shall provide the Illinois Department

1 access to confidential and other information and data  
2 necessary to perform eligibility and payment verifications and  
3 other Illinois Department functions. This includes, but is not  
4 limited to: information pertaining to licensure;  
5 certification; earnings; immigration status; citizenship; wage  
6 reporting; unearned and earned income; pension income;  
7 employment; supplemental security income; social security  
8 numbers; National Provider Identifier (NPI) numbers; the  
9 National Practitioner Data Bank (NPDB); program and agency  
10 exclusions; taxpayer identification numbers; tax delinquency;  
11 corporate information; and death records.

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

1 Human Services; and the Department of Financial and  
2 Professional Regulation.

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

17 The Illinois Department shall establish policies,  
18 procedures, standards and criteria by rule for the  
19 acquisition, repair and replacement of orthotic and prosthetic  
20 devices and durable medical equipment. Such rules shall  
21 provide, but not be limited to, the following services: (1)  
22 immediate repair or replacement of such devices by recipients;  
23 and (2) rental, lease, purchase or lease-purchase of durable  
24 medical equipment in a cost-effective manner, taking into  
25 consideration the recipient's medical prognosis, the extent of  
26 the recipient's needs, and the requirements and costs for

1 maintaining such equipment. Subject to prior approval, such  
2 rules shall enable a recipient to temporarily acquire and use  
3 alternative or substitute devices or equipment pending repairs  
4 or replacements of any device or equipment previously  
5 authorized for such recipient by the Department.  
6 Notwithstanding any provision of Section 5-5f to the contrary,  
7 the Department may, by rule, exempt certain replacement  
8 wheelchair parts from prior approval and, for wheelchairs,  
9 wheelchair parts, wheelchair accessories, and related seating  
10 and positioning items, determine the wholesale price by  
11 methods other than actual acquisition costs.

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

20 In order to promote environmental responsibility, meet the  
21 needs of recipients and enrollees, and achieve significant  
22 cost savings, the Department, or a managed care organization  
23 under contract with the Department, may provide recipients or  
24 managed care enrollees who have a prescription or Certificate  
25 of Medical Necessity access to refurbished durable medical  
26 equipment under this Section (excluding prosthetic and

1 orthotic devices as defined in the Orthotics, Prosthetics, and  
2 Pedorthics Practice Act and complex rehabilitation technology  
3 products and associated services) through the State's  
4 assistive technology program's reutilization program, using  
5 staff with the Assistive Technology Professional (ATP)  
6 Certification if the refurbished durable medical equipment:  
7 (i) is available; (ii) is less expensive, including shipping  
8 costs, than new durable medical equipment of the same type;  
9 (iii) is able to withstand at least 3 years of use; (iv) is  
10 cleaned, disinfected, sterilized, and safe in accordance with  
11 federal Food and Drug Administration regulations and guidance  
12 governing the reprocessing of medical devices in health care  
13 settings; and (v) equally meets the needs of the recipient or  
14 enrollee. The reutilization program shall confirm that the  
15 recipient or enrollee is not already in receipt of the same or  
16 similar equipment from another service provider, and that the  
17 refurbished durable medical equipment equally meets the needs  
18 of the recipient or enrollee. Nothing in this paragraph shall  
19 be construed to limit recipient or enrollee choice to obtain  
20 new durable medical equipment or place any additional prior  
21 authorization conditions on enrollees of managed care  
22 organizations.

23 The Department shall execute, relative to the nursing home  
24 prescreening project, written inter-agency agreements with the  
25 Department of Human Services and the Department on Aging, to  
26 effect the following: (i) intake procedures and common

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

1 approval has been granted.

2 The Illinois Department shall develop and operate, in  
3 cooperation with other State Departments and agencies and in  
4 compliance with applicable federal laws and regulations,  
5 appropriate and effective systems of health care evaluation  
6 and programs for monitoring of utilization of health care  
7 services and facilities, as it affects persons eligible for  
8 medical assistance under this Code.

9 The Illinois Department shall report annually to the  
10 General Assembly, no later than the second Friday in April of  
11 1979 and each year thereafter, in regard to:

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

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

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

18 (d) efforts at utilization review and control by the  
19 Illinois Department.

20 The period covered by each report shall be the 3 years  
21 ending on the June 30 prior to the report. The report shall  
22 include suggested legislation for consideration by the General  
23 Assembly. The requirement for reporting to the General  
24 Assembly shall be satisfied by filing copies of the report as  
25 required by Section 3.1 of the General Assembly Organization  
26 Act, and filing such additional copies with the State

1 Government Report Distribution Center for the General Assembly  
2 as is required under paragraph (t) of Section 7 of the State  
3 Library Act.

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

10 On and after July 1, 2012, the Department shall reduce any  
11 rate of reimbursement for services or other payments or alter  
12 any methodologies authorized by this Code to reduce any rate  
13 of reimbursement for services or other payments in accordance  
14 with Section 5-5e.

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

1 Providers under this Section shall be prior approved and  
2 certified by the Department to perform kidney transplantation  
3 and the services under this Section shall be limited to  
4 services associated with kidney transplantation.

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

17 On or after July 1, 2015, opioid antagonists prescribed  
18 for the treatment of an opioid overdose, including the  
19 medication product, administration devices, and any pharmacy  
20 fees or hospital fees related to the dispensing, distribution,  
21 and administration of the opioid antagonist, shall be covered  
22 under the medical assistance program for persons who are  
23 otherwise eligible for medical assistance under this Article.  
24 As used in this Section, "opioid antagonist" means a drug that  
25 binds to opioid receptors and blocks or inhibits the effect of  
26 opioids acting on those receptors, including, but not limited

1 to, naloxone hydrochloride or any other similarly acting drug  
2 approved by the U.S. Food and Drug Administration. The  
3 Department shall not impose a copayment on the coverage  
4 provided for naloxone hydrochloride under the medical  
5 assistance program.

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

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

26 Within 90 days after October 8, 2021 (the effective date

1 of Public Act 102-665), the Department shall seek federal  
2 approval of a State Plan amendment to expand coverage for  
3 family planning services that includes presumptive eligibility  
4 to individuals whose income is at or below 208% of the federal  
5 poverty level. Coverage under this Section shall be effective  
6 beginning no later than December 1, 2022.

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

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

23 Notwithstanding any other provision of this Code, within  
24 12 months after June 2, 2022 (the effective date of Public Act  
25 102-1037) and subject to federal approval, acupuncture  
26 services performed by an acupuncturist licensed under the

1 Acupuncture Practice Act who is acting within the scope of his  
2 or her license shall be covered under the medical assistance  
3 program. The Department shall apply for any federal waiver or  
4 State Plan amendment, if required, to implement this  
5 paragraph. The Department may adopt any rules, including  
6 standards and criteria, necessary to implement this paragraph.

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

25 Notwithstanding any other provision of this Code,  
26 beginning on January 1, 2024, subject to federal approval,

1 cognitive assessment and care planning services provided to a  
2 person who experiences signs or symptoms of cognitive  
3 impairment, as defined by the Diagnostic and Statistical  
4 Manual of Mental Disorders, Fifth Edition, shall be covered  
5 under the medical assistance program for persons who are  
6 otherwise eligible for medical assistance under this Article.

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

15 Notwithstanding any other provision of this Code,  
16 hypoallergenic formula shall be covered under the medical  
17 assistance program for persons otherwise eligible for medical  
18 assistance who have been prescribed hypoallergenic formula by  
19 a physician. The Department shall apply for any federal  
20 waivers or approvals necessary to implement this paragraph.  
21 Upon federal approval, the Department shall at a minimum  
22 determine by rule the amount of hypoallergenic formula an  
23 eligible person shall receive coverage for per day.

24 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;  
25 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article  
26 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,

1 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;  
2 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.  
3 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;  
4 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.  
5 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;  
6 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.  
7 1-1-24; 103-593, Article 5, Section 5-5, eff. 6-7-24; 103-593,  
8 Article 90, Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24;  
9 103-808, eff. 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff.  
10 8-9-24; revised 10-10-24.)

11 Section 95. No acceleration or delay. Where this Act makes  
12 changes in a statute that is represented in this Act by text  
13 that is not yet or no longer in effect (for example, a Section  
14 represented by multiple versions), the use of that text does  
15 not accelerate or delay the taking effect of (i) the changes  
16 made by this Act or (ii) provisions derived from any other  
17 Public Act.