



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB1743

Introduced 2/5/2025, by Sen. Lakesia Collins

SYNOPSIS AS INTRODUCED:

225 ILCS 15/2 from Ch. 111, par. 5352
225 ILCS 15/4.3
305 ILCS 5/5-5
720 ILCS 570/303.05

Amends the Clinical Psychologist Licensing Act. In provisions concerning written collaborative agreements, removes a provision prohibiting a prescribing psychologist from prescribing medications to patients who are less than 17 years of age or over 65 years of age. Provides that no prescriptive authority for any Schedule II opioid shall be delegated. Provides that after the collaborating physician files a notice delegating authority to prescribe any nonnarcotic, nonopioid Schedule II through V controlled substances (rather than any nonnarcotic Schedule III through V controlled substances), the licensed clinical psychologist shall be eligible to register for a mid-level practitioner controlled substance license under the Illinois Controlled Substances Act. Defines "opioid". Makes corresponding changes in the Illinois Controlled Substances Act. Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that the Department of Healthcare and Family Services shall provide coverage and reimbursement for prescription management services provided by prescribing psychologists for persons who are otherwise eligible for medical assistance under the Article. Effective immediately.

LRB104 11917 AAS 22009 b

1 AN ACT concerning regulation.

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

4 Section 5. The Clinical Psychologist Licensing Act is
5 amended by changing Sections 2 and 4.3 as follows:

6 (225 ILCS 15/2) (from Ch. 111, par. 5352)

7 (Section scheduled to be repealed on January 1, 2027)

8 Sec. 2. Definitions. As used in this Act:

9 (1) "Department" means the Department of Financial and
10 Professional Regulation.

11 (2) "Secretary" means the Secretary of Financial and
12 Professional Regulation.

13 (3) "Board" means the Clinical Psychologists Licensing
14 and Disciplinary Board appointed by the Secretary.

15 (4) (Blank).

16 (5) "Clinical psychology" means the independent
17 evaluation, classification, diagnosis, and treatment of
18 mental, emotional, behavioral or nervous disorders or
19 conditions, developmental disabilities, alcoholism and
20 substance abuse, disorders of habit or conduct, and the
21 psychological aspects of physical illness. The practice of
22 clinical psychology includes psychoeducational
23 evaluation, therapy, remediation and consultation, the use

1 of psychological and neuropsychological testing,
2 assessment, psychotherapy, psychoanalysis, hypnosis,
3 biofeedback, and behavioral modification when any of these
4 are used for the purpose of preventing or eliminating
5 psychopathology, or for the amelioration of psychological
6 disorders of individuals or groups. "Clinical psychology"
7 does not include the use of hypnosis by unlicensed persons
8 pursuant to Section 3.

9 (6) A person represents himself or herself to be a
10 "clinical psychologist" or "psychologist" within the
11 meaning of this Act when he or she holds himself or herself
12 out to the public by any title or description of services
13 incorporating the words "psychological", "psychologic",
14 "psychologist", "psychology", or "clinical psychologist"
15 or under such title or description offers to render or
16 renders clinical psychological services as defined in
17 paragraph (7) of this Section to individuals or the public
18 for remuneration.

19 (7) "Clinical psychological services" refers to any
20 services under paragraph (5) of this Section if the words
21 "psychological", "psychologic", "psychologist",
22 "psychology" or "clinical psychologist" are used to
23 describe such services by the person or organization
24 offering to render or rendering them.

25 (8) "Collaborating physician" means a physician
26 licensed to practice medicine in all of its branches in

1 Illinois who generally prescribes medications for the
2 treatment of mental health disease or illness to his or
3 her patients in the normal course of his or her clinical
4 medical practice.

5 (9) "Prescribing psychologist" means a licensed,
6 doctoral level psychologist who has undergone specialized
7 training, has passed an examination as determined by rule,
8 and has received a current license granting prescriptive
9 authority under Section 4.2 of this Act that has not been
10 revoked or suspended from the Department.

11 (10) "Prescriptive authority" means the authority to
12 prescribe, administer, discontinue, or distribute drugs or
13 medicines.

14 (11) "Prescription" means an order for a drug,
15 laboratory test, or any medicines, including controlled
16 substances as defined in the Illinois Controlled
17 Substances Act.

18 (12) "Drugs" has the meaning given to that term in the
19 Pharmacy Practice Act.

20 (13) "Medicines" has the meaning given to that term in
21 the Pharmacy Practice Act.

22 (14) "Address of record" means the designated address
23 recorded by the Department in the applicant's application
24 file or the licensee's license file maintained by the
25 Department's licensure maintenance unit.

26 (15) "Opioid" means a narcotic drug or substance that

1 is a Schedule II controlled substance under paragraph (1),
2 (2), (3), or (5) of subsection (b) or under subsection (c)
3 of Section 206 of the Illinois Controlled Substances Act.

4 This Act shall not apply to persons lawfully carrying on
5 their particular profession or business under any valid
6 existing regulatory Act of the State.

7 (Source: P.A. 98-668, eff. 6-25-14; 99-572, eff. 7-15-16.)

8 (225 ILCS 15/4.3)

9 (Section scheduled to be repealed on January 1, 2027)

10 Sec. 4.3. Written collaborative agreements.

11 (a) A written collaborative agreement is required for all
12 prescribing psychologists practicing under a prescribing
13 psychologist license issued pursuant to Section 4.2 of this
14 Act.

15 (b) A written delegation of prescriptive authority by a
16 collaborating physician may only include medications for the
17 treatment of mental health disease or illness the
18 collaborating physician generally provides to his or her
19 patients in the normal course of his or her clinical practice
20 with the exception of the following:

21 (1) (blank); ~~patients who are less than 17 years of~~
22 ~~age or over 65 years of age;~~

23 (2) patients during pregnancy;

24 (3) patients with serious medical conditions, such as
25 heart disease, cancer, stroke, or seizures, and with

developmental disabilities and intellectual disabilities;

~~and~~

(4) prescriptive authority for benzodiazepine Schedule III controlled substances; and -

(5) prescriptive authority for any Schedule II opioid.

(c) The collaborating physician shall file with the Department notice of delegation of prescriptive authority and termination of the delegation, in accordance with rules of the Department. Upon receipt of this notice delegating authority to prescribe any nonnarcotic, nonopioid Schedule II ~~III~~ through V controlled substances, the licensed clinical psychologist shall be eligible to register for a mid-level practitioner controlled substance license under Section 303.05 of the Illinois Controlled Substances Act.

(d) All of the following shall apply to delegation of prescriptive authority:

(1) Any delegation of Schedule II ~~III~~ through V controlled substances shall identify the specific controlled substance by brand name or generic name. No controlled substance to be delivered by injection may be delegated. No Schedule II opioid ~~controlled substance~~ shall be delegated.

(2) A prescribing psychologist shall not prescribe narcotic drugs, as defined in Section 102 of the Illinois Controlled Substances Act.

Any prescribing psychologist who writes a prescription for

1 a controlled substance without having valid and appropriate
2 authority may be fined by the Department not more than \$50 per
3 prescription and the Department may take any other
4 disciplinary action provided for in this Act.

5 All prescriptions written by a prescribing psychologist
6 must contain the name of the prescribing psychologist and his
7 or her signature. The prescribing psychologist shall sign his
8 or her own name.

9 (e) The written collaborative agreement shall describe the
10 working relationship of the prescribing psychologist with the
11 collaborating physician and shall delegate prescriptive
12 authority as provided in this Act. Collaboration does not
13 require an employment relationship between the collaborating
14 physician and prescribing psychologist. Absent an employment
15 relationship, an agreement may not restrict third-party
16 payment sources accepted by the prescribing psychologist. For
17 the purposes of this Section, "collaboration" means the
18 relationship between a prescribing psychologist and a
19 collaborating physician with respect to the delivery of
20 prescribing services in accordance with (1) the prescribing
21 psychologist's training, education, and experience and (2)
22 collaboration and consultation as documented in a jointly
23 developed written collaborative agreement.

24 (f) The agreement shall promote the exercise of
25 professional judgment by the prescribing psychologist
26 corresponding to his or her education and experience.

1 (g) The collaborative agreement shall not be construed to
2 require the personal presence of a physician at the place
3 where services are rendered. Methods of communication shall be
4 available for consultation with the collaborating physician in
5 person or by telecommunications in accordance with established
6 written guidelines as set forth in the written agreement.

7 (h) Collaboration and consultation pursuant to all
8 collaboration agreements shall be adequate if a collaborating
9 physician does each of the following:

10 (1) participates in the joint formulation and joint
11 approval of orders or guidelines with the prescribing
12 psychologist and he or she periodically reviews the
13 prescribing psychologist's orders and the services
14 provided patients under the orders in accordance with
15 accepted standards of medical practice and prescribing
16 psychologist practice;

17 (2) provides collaboration and consultation with the
18 prescribing psychologist in person at least once a month
19 for review of safety and quality clinical care or
20 treatment;

21 (3) is available through telecommunications for
22 consultation on medical problems, complications,
23 emergencies, or patient referral; and

24 (4) reviews medication orders of the prescribing
25 psychologist no less than monthly, including review of
26 laboratory tests and other tests as available.

1 (i) The written collaborative agreement shall contain
2 provisions detailing notice for termination or change of
3 status involving a written collaborative agreement, except
4 when the notice is given for just cause.

5 (j) A copy of the signed written collaborative agreement
6 shall be available to the Department upon request to either
7 the prescribing psychologist or the collaborating physician.

8 (k) Nothing in this Section shall be construed to limit
9 the authority of a prescribing psychologist to perform all
10 duties authorized under this Act.

11 (l) A prescribing psychologist shall inform each
12 collaborating physician of all collaborative agreements he or
13 she has signed and provide a copy of these to any collaborating
14 physician.

15 (m) No collaborating physician shall enter into more than
16 3 collaborative agreements with prescribing psychologists.

17 (Source: P.A. 101-84, eff. 7-19-19.)

18 Section 10. The Illinois Public Aid Code is amended by
19 changing Section 5-5 as follows:

20 (305 ILCS 5/5-5)

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

22 Sec. 5-5. Medical services. The Illinois Department, by
23 rule, shall determine the quantity and quality of and the rate
24 of reimbursement for the medical assistance for which payment

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

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

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

1 persons who are otherwise eligible for assistance under this
2 Article.

3 Notwithstanding any other provision of this Code,
4 reproductive health care that is otherwise legal in Illinois
5 shall be covered under the medical assistance program for
6 persons who are otherwise eligible for medical assistance
7 under this Article.

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

1 plan, and all other necessary documentation to the Centers for
2 Medicare and Medicaid Services for review and approval.
3 Coverage under this paragraph shall be contingent upon federal
4 approval.

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

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

1 Department or the MCE in which the individual is enrolled for
2 payment and shall be reimbursed at the Department's or the
3 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

26 On and after July 1, 2018, targeted dental services, as

1 set forth in Exhibit D of the Consent Decree entered by the
2 United States District Court for the Northern District of
3 Illinois, Eastern Division, in the matter of Memisovski v.
4 Maram, Case No. 92 C 1982, that are provided to adults under
5 the medical assistance program shall be established at no less
6 than the rates set forth in the "New Rate" column in Exhibit D
7 of the Consent Decree for targeted dental services that are
8 provided to persons under the age of 18 under the medical
9 assistance program.

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

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

1 Section are performed. The Department shall establish a
2 process for payment of claims for reimbursement for covered
3 dental services rendered under this provision.

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

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

1 school-based dental program in addition to, or independent of,
2 the school-based dental program administered by the
3 Department.

4 The Illinois Department, by rule, may distinguish and
5 classify the medical services to be provided only in
6 accordance with the classes of persons designated in Section
7 5-2.

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

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

20 (A) A baseline mammogram for individuals 35 to 39
21 years of age.

22 (B) An annual mammogram for individuals 40 years of
23 age or older.

24 (C) A mammogram at the age and intervals considered
25 medically necessary by the individual's health care
26 provider for individuals under 40 years of age and having

1 a family history of breast cancer, prior personal history
2 of breast cancer, positive genetic testing, or other risk
3 factors.

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

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

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

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

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

1 tool.

2 For purposes of this Section:

3 "Diagnostic mammogram" means a mammogram obtained using
4 diagnostic mammography.

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

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

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

21 If, at any time, the Secretary of the United States
22 Department of Health and Human Services, or its successor
23 agency, promulgates rules or regulations to be published in
24 the Federal Register or publishes a comment in the Federal
25 Register or issues an opinion, guidance, or other action that
26 would require the State, pursuant to any provision of the

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

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

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

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

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

7 The Department shall convene an expert panel, including
8 representatives of hospitals, free-standing breast cancer
9 treatment centers, breast cancer quality organizations, and
10 doctors, including breast surgeons, reconstructive breast
11 surgeons, oncologists, and primary care providers to establish
12 quality standards for breast cancer treatment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 abuse.

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

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

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

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

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

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

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

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

26 Nothing in this Section shall limit the free choice of

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

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

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

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

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

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

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

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

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

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

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

26 Prior to enrollment and during the conditional enrollment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 Notwithstanding any other provision of this Code to the

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

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

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

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

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

1 beginning no later than December 1, 2022.

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

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

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

1 standards and criteria, necessary to implement this paragraph.

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

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

1 otherwise eligible for medical assistance under this Article.

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

10 Notwithstanding any other provision of this Code, the
11 Department shall provide coverage and reimbursement for
12 prescription management services provided by prescribing
13 psychologists for persons who are otherwise eligible for
14 medical assistance under this Article.

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

1 10-10-24.)

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

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

1 diagnostic, screening, preventive, and rehabilitative
2 services, including to ensure that the individual's need for
3 intervention or treatment of mental disorders or substance use
4 disorders or co-occurring mental health and substance use
5 disorders is determined using a uniform screening, assessment,
6 and evaluation process inclusive of criteria, for children and
7 adults; for purposes of this item (13), a uniform screening,
8 assessment, and evaluation process refers to a process that
9 includes an appropriate evaluation and, as warranted, a
10 referral; "uniform" does not mean the use of a singular
11 instrument, tool, or process that all must utilize; (14)
12 transportation and such other expenses as may be necessary;
13 (15) medical treatment of sexual assault survivors, as defined
14 in Section 1a of the Sexual Assault Survivors Emergency
15 Treatment Act, for injuries sustained as a result of the
16 sexual assault, including examinations and laboratory tests to
17 discover evidence which may be used in criminal proceedings
18 arising from the sexual assault; (16) the diagnosis and
19 treatment of sickle cell anemia; (16.5) services performed by
20 a chiropractic physician licensed under the Medical Practice
21 Act of 1987 and acting within the scope of his or her license,
22 including, but not limited to, chiropractic manipulative
23 treatment; and (17) any other medical care, and any other type
24 of remedial care recognized under the laws of this State. The
25 term "any other type of remedial care" shall include nursing
26 care and nursing home service for persons who rely on

1 treatment by spiritual means alone through prayer for healing.

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

9 Notwithstanding any other provision of this Code,
10 reproductive health care that is otherwise legal in Illinois
11 shall be covered under the medical assistance program for
12 persons who are otherwise eligible for medical assistance
13 under this Article.

14 Notwithstanding any other provision of this Section, all
15 tobacco cessation medications approved by the United States
16 Food and Drug Administration and all individual and group
17 tobacco cessation counseling services and telephone-based
18 counseling services and tobacco cessation medications provided
19 through the Illinois Tobacco Quitline shall be covered under
20 the medical assistance program for persons who are otherwise
21 eligible for assistance under this Article. The Department
22 shall comply with all federal requirements necessary to obtain
23 federal financial participation, as specified in 42 CFR
24 433.15(b) (7), for telephone-based counseling services provided
25 through the Illinois Tobacco Quitline, including, but not
26 limited to: (i) entering into a memorandum of understanding or

1 interagency agreement with the Department of Public Health, as
2 administrator of the Illinois Tobacco Quitline; and (ii)
3 developing a cost allocation plan for Medicaid-allowable
4 Illinois Tobacco Quitline services in accordance with 45 CFR
5 95.507. The Department shall submit the memorandum of
6 understanding or interagency agreement, the cost allocation
7 plan, and all other necessary documentation to the Centers for
8 Medicare and Medicaid Services for review and approval.
9 Coverage under this paragraph shall be contingent upon federal
10 approval.

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

18 Upon receipt of federal approval of an amendment to the
19 Illinois Title XIX State Plan for this purpose, the Department
20 shall authorize the Chicago Public Schools (CPS) to procure a
21 vendor or vendors to manufacture eyeglasses for individuals
22 enrolled in a school within the CPS system. CPS shall ensure
23 that its vendor or vendors are enrolled as providers in the
24 medical assistance program and in any capitated Medicaid
25 managed care entity (MCE) serving individuals enrolled in a
26 school within the CPS system. Under any contract procured

1 under this provision, the vendor or vendors must serve only
2 individuals enrolled in a school within the CPS system. Claims
3 for services provided by CPS's vendor or vendors to recipients
4 of benefits in the medical assistance program under this Code,
5 the Children's Health Insurance Program, or the Covering ALL
6 KIDS Health Insurance Program shall be submitted to the
7 Department or the MCE in which the individual is enrolled for
8 payment and shall be reimbursed at the Department's or the
9 MCE's established rates or rate methodologies for eyeglasses.

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

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

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

21 On and after July 1, 2018, the Department of Healthcare
22 and Family Services shall provide dental services to any adult
23 who is otherwise eligible for assistance under the medical
24 assistance program. As used in this paragraph, "dental
25 services" means diagnostic, preventative, restorative, or
26 corrective procedures, including procedures and services for

1 the prevention and treatment of periodontal disease and dental
2 caries disease, provided by an individual who is licensed to
3 practice dentistry or dental surgery or who is under the
4 supervision of a dentist in the practice of his or her
5 profession.

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

16 Subject to federal approval, on and after January 1, 2025,
17 the rates paid for sedation evaluation and the provision of
18 deep sedation and intravenous sedation for the purpose of
19 dental services shall be increased by 33% above the rates in
20 effect on December 31, 2024. The rates paid for nitrous oxide
21 sedation shall not be impacted by this paragraph and shall
22 remain the same as the rates in effect on December 31, 2024.

23 Notwithstanding any other provision of this Code and
24 subject to federal approval, the Department may adopt rules to
25 allow a dentist who is volunteering his or her service at no
26 cost to render dental services through an enrolled

1 not-for-profit health clinic without the dentist personally
2 enrolling as a participating provider in the medical
3 assistance program. A not-for-profit health clinic shall
4 include a public health clinic or Federally Qualified Health
5 Center or other enrolled provider, as determined by the
6 Department, through which dental services covered under this
7 Section are performed. The Department shall establish a
8 process for payment of claims for reimbursement for covered
9 dental services rendered under this provision.

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

14 On and after January 1, 2022, the Department of Healthcare
15 and Family Services shall administer and regulate a
16 school-based dental program that allows for the out-of-office
17 delivery of preventative dental services in a school setting
18 to children under 19 years of age. The Department shall
19 establish, by rule, guidelines for participation by providers
20 and set requirements for follow-up referral care based on the
21 requirements established in the Dental Office Reference Manual
22 published by the Department that establishes the requirements
23 for dentists participating in the All Kids Dental School
24 Program. Every effort shall be made by the Department when
25 developing the program requirements to consider the different
26 geographic differences of both urban and rural areas of the

1 State for initial treatment and necessary follow-up care. No
2 provider shall be charged a fee by any unit of local government
3 to participate in the school-based dental program administered
4 by the Department. Nothing in this paragraph shall be
5 construed to limit or preempt a home rule unit's or school
6 district's authority to establish, change, or administer a
7 school-based dental program in addition to, or independent of,
8 the school-based dental program administered by the
9 Department.

10 The Illinois Department, by rule, may distinguish and
11 classify the medical services to be provided only in
12 accordance with the classes of persons designated in Section
13 5-2.

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

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

26 (A) A baseline mammogram for individuals 35 to 39

1 years of age.

2 (B) An annual mammogram for individuals 40 years of
3 age or older.

4 (C) A mammogram at the age and intervals considered
5 medically necessary by the individual's health care
6 provider for individuals under 40 years of age and having
7 a family history of breast cancer, prior personal history
8 of breast cancer, positive genetic testing, or other risk
9 factors.

10 (D) A comprehensive ultrasound screening and MRI of an
11 entire breast or breasts if a mammogram demonstrates
12 heterogeneous or dense breast tissue or when medically
13 necessary as determined by a physician licensed to
14 practice medicine in all of its branches.

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

18 (F) A diagnostic mammogram when medically necessary,
19 as determined by a physician licensed to practice medicine
20 in all its branches, advanced practice registered nurse,
21 or physician assistant.

22 (G) Molecular breast imaging (MBI) and MRI of an
23 entire breast or breasts if a mammogram demonstrates
24 heterogeneous or dense breast tissue or when medically
25 necessary as determined by a physician licensed to
26 practice medicine in all of its branches, advanced

1 practice registered nurse, or physician assistant.

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

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

14 For purposes of this Section:

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

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

22 "Low-dose mammography" means the x-ray examination of the
23 breast using equipment dedicated specifically for mammography,
24 including the x-ray tube, filter, compression device, and
25 image receptor, with an average radiation exposure delivery of
26 less than one rad per breast for 2 views of an average size

1 breast. The term also includes digital mammography and
2 includes breast tomosynthesis.

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

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

23 On and after January 1, 2016, the Department shall ensure
24 that all networks of care for adult clients of the Department
25 include access to at least one breast imaging Center of
26 Imaging Excellence as certified by the American College of

1 Radiology.

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

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

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

19 The Department shall convene an expert panel, including
20 representatives of hospitals, free-standing breast cancer
21 treatment centers, breast cancer quality organizations, and
22 doctors, including radiologists that are trained in all forms
23 of FDA-approved ~~FDA-approved~~ breast imaging technologies,
24 breast surgeons, reconstructive breast surgeons, oncologists,
25 and primary care providers to establish quality standards for
26 breast cancer treatment.

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

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

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

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

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

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

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

1 progression. The Department shall disallow any
2 preauthorization requirements for the administration of the
3 human papillomavirus (HPV) vaccine.

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

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

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

1 individuals, including information on appropriate referrals
2 for other social services that may be needed by addicted
3 individuals in addition to treatment for addiction.

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

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

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

25 The Illinois Department may develop and contract with
26 Partnerships of medical providers to arrange medical services

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

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

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

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

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

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

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

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

26 The Illinois Department shall require health care

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

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

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

26 Notwithstanding any other law to the contrary, the

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

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

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

1 liens for the Illinois Department.

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

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

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

26 The Department shall define or specify the following: (i)

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

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

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

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

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

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

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

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

1 rejection are subject to receipt no later than 180 days after
2 the admission transaction has been completed.

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

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

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

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

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

26 The Illinois Department shall establish policies,

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

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

1 of the rule adopted pursuant to this paragraph, all providers
2 must meet the accreditation requirement.

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

1 of the recipient or enrollee. Nothing in this paragraph shall
2 be construed to limit recipient or enrollee choice to obtain
3 new durable medical equipment or place any additional prior
4 authorization conditions on enrollees of managed care
5 organizations.

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

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

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

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

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

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

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

1 (d) efforts at utilization review and control by the
2 Illinois Department.

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

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

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

24 Because kidney transplantation can be an appropriate,
25 cost-effective alternative to renal dialysis when medically
26 necessary and notwithstanding the provisions of Section 1-11

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

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

26 On or after July 1, 2015, opioid antagonists prescribed

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

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

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

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

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

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

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

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

1 Public Act 103-909) ~~this amendatory Act of the 103rd General~~
2 ~~Assembly~~ to the Newborn Metabolic Screening Act and required
3 to be performed under that Act at a rate not less than the fee
4 charged by the Department of Public Health. The Department
5 shall seek federal approval before the implementation of the
6 newborn screening test fees by the Department of Public
7 Health.

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

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

24 Notwithstanding any other provision of this Code, the
25 Department shall provide coverage and reimbursement for
26 prescription management services provided by prescribing

1 psychologists for persons who are otherwise eligible for
2 medical assistance under this Article.

3 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;
4 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article
5 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,
6 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;
7 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.
8 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;
9 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.
10 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;
11 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.
12 1-1-24; 103-593, Article 5, Section 5-5, eff. 6-7-24; 103-593,
13 Article 90, Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24;
14 103-808, eff. 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff.
15 8-9-24; revised 10-10-24.)

16 Section 15. The Illinois Controlled Substances Act is
17 amended by changing Section 303.05 as follows:

18 (720 ILCS 570/303.05)

19 Sec. 303.05. Mid-level practitioner registration.

20 (a) The Department of Financial and Professional
21 Regulation shall register licensed physician assistants,
22 licensed advanced practice registered nurses, and prescribing
23 psychologists licensed under Section 4.2 of the Clinical
24 Psychologist Licensing Act to prescribe and dispense

1 controlled substances under Section 303 and euthanasia
2 agencies to purchase, store, or administer animal euthanasia
3 drugs under the following circumstances:

4 (1) with respect to physician assistants,

5 (A) the physician assistant has been delegated
6 written authority to prescribe any Schedule III
7 through V controlled substances by a physician
8 licensed to practice medicine in all its branches in
9 accordance with Section 7.5 of the Physician Assistant
10 Practice Act of 1987; and the physician assistant has
11 completed the appropriate application forms and has
12 paid the required fees as set by rule; or

13 (B) the physician assistant has been delegated
14 authority by a collaborating physician licensed to
15 practice medicine in all its branches to prescribe or
16 dispense Schedule II controlled substances through a
17 written delegation of authority and under the
18 following conditions:

19 (i) Specific Schedule II controlled substances
20 by oral dosage or topical or transdermal
21 application may be delegated, provided that the
22 delegated Schedule II controlled substances are
23 routinely prescribed by the collaborating
24 physician. This delegation must identify the
25 specific Schedule II controlled substances by
26 either brand name or generic name. Schedule II

1 controlled substances to be delivered by injection
2 or other route of administration may not be
3 delegated;

4 (ii) any delegation must be of controlled
5 substances prescribed by the collaborating
6 physician;

7 (iii) all prescriptions must be limited to no
8 more than a 30-day supply, with any continuation
9 authorized only after prior approval of the
10 collaborating physician;

11 (iv) the physician assistant must discuss the
12 condition of any patients for whom a controlled
13 substance is prescribed monthly with the
14 delegating physician;

15 (v) the physician assistant must have
16 completed the appropriate application forms and
17 paid the required fees as set by rule;

18 (vi) the physician assistant must provide
19 evidence of satisfactory completion of 45 contact
20 hours in pharmacology from any physician assistant
21 program accredited by the Accreditation Review
22 Commission on Education for the Physician
23 Assistant (ARC-PA), or its predecessor agency, for
24 any new license issued with Schedule II authority
25 after the effective date of this amendatory Act of
26 the 97th General Assembly; and

1 (vii) the physician assistant must annually
2 complete at least 5 hours of continuing education
3 in pharmacology;

4 (2) with respect to advanced practice registered
5 nurses who do not meet the requirements of Section 65-43
6 of the Nurse Practice Act,

7 (A) the advanced practice registered nurse has
8 been delegated authority to prescribe any Schedule III
9 through V controlled substances by a collaborating
10 physician licensed to practice medicine in all its
11 branches or a collaborating podiatric physician in
12 accordance with Section 65-40 of the Nurse Practice
13 Act. The advanced practice registered nurse has
14 completed the appropriate application forms and has
15 paid the required fees as set by rule; or

16 (B) the advanced practice registered nurse has
17 been delegated authority by a collaborating physician
18 licensed to practice medicine in all its branches to
19 prescribe or dispense Schedule II controlled
20 substances through a written delegation of authority
21 and under the following conditions:

22 (i) specific Schedule II controlled substances
23 by oral dosage or topical or transdermal
24 application may be delegated, provided that the
25 delegated Schedule II controlled substances are
26 routinely prescribed by the collaborating

1 physician. This delegation must identify the
2 specific Schedule II controlled substances by
3 either brand name or generic name. Schedule II
4 controlled substances to be delivered by injection
5 or other route of administration may not be
6 delegated;

7 (ii) any delegation must be of controlled
8 substances prescribed by the collaborating
9 physician;

10 (iii) all prescriptions must be limited to no
11 more than a 30-day supply, with any continuation
12 authorized only after prior approval of the
13 collaborating physician;

14 (iv) the advanced practice registered nurse
15 must discuss the condition of any patients for
16 whom a controlled substance is prescribed monthly
17 with the delegating physician or in the course of
18 review as required by Section 65-40 of the Nurse
19 Practice Act;

20 (v) the advanced practice registered nurse
21 must have completed the appropriate application
22 forms and paid the required fees as set by rule;

23 (vi) the advanced practice registered nurse
24 must provide evidence of satisfactory completion
25 of at least 45 graduate contact hours in
26 pharmacology for any new license issued with

1 Schedule II authority after the effective date of
2 this amendatory Act of the 97th General Assembly;
3 and

4 (vii) the advanced practice registered nurse
5 must annually complete 5 hours of continuing
6 education in pharmacology;

7 (2.5) with respect to advanced practice registered
8 nurses certified as nurse practitioners, nurse midwives,
9 or clinical nurse specialists who do not meet the
10 requirements of Section 65-43 of the Nurse Practice Act
11 practicing in a hospital affiliate,

12 (A) the advanced practice registered nurse
13 certified as a nurse practitioner, nurse midwife, or
14 clinical nurse specialist has been privileged to
15 prescribe any Schedule II through V controlled
16 substances by the hospital affiliate upon the
17 recommendation of the appropriate physician committee
18 of the hospital affiliate in accordance with Section
19 65-45 of the Nurse Practice Act, has completed the
20 appropriate application forms, and has paid the
21 required fees as set by rule; and

22 (B) an advanced practice registered nurse
23 certified as a nurse practitioner, nurse midwife, or
24 clinical nurse specialist has been privileged to
25 prescribe any Schedule II controlled substances by the
26 hospital affiliate upon the recommendation of the

1 appropriate physician committee of the hospital
2 affiliate, then the following conditions must be met:

3 (i) specific Schedule II controlled substances
4 by oral dosage or topical or transdermal
5 application may be designated, provided that the
6 designated Schedule II controlled substances are
7 routinely prescribed by advanced practice
8 registered nurses in their area of certification;
9 the privileging documents must identify the
10 specific Schedule II controlled substances by
11 either brand name or generic name; privileges to
12 prescribe or dispense Schedule II controlled
13 substances to be delivered by injection or other
14 route of administration may not be granted;

15 (ii) any privileges must be controlled
16 substances limited to the practice of the advanced
17 practice registered nurse;

18 (iii) any prescription must be limited to no
19 more than a 30-day supply;

20 (iv) the advanced practice registered nurse
21 must discuss the condition of any patients for
22 whom a controlled substance is prescribed monthly
23 with the appropriate physician committee of the
24 hospital affiliate or its physician designee; and

25 (v) the advanced practice registered nurse
26 must meet the education requirements of this

1 Section;

2 (3) with respect to animal euthanasia agencies, the
3 euthanasia agency has obtained a license from the
4 Department of Financial and Professional Regulation and
5 obtained a registration number from the Department; or

6 (4) with respect to prescribing psychologists, the
7 prescribing psychologist has been delegated authority to
8 prescribe any nonnarcotic, nonopioid Schedule II ~~III~~
9 through V controlled substances by a collaborating
10 physician licensed to practice medicine in all its
11 branches in accordance with Section 4.3 of the Clinical
12 Psychologist Licensing Act, and the prescribing
13 psychologist has completed the appropriate application
14 forms and has paid the required fees as set by rule.

15 (b) The mid-level practitioner shall only be licensed to
16 prescribe those schedules of controlled substances for which a
17 licensed physician has delegated prescriptive authority,
18 except that an animal euthanasia agency does not have any
19 prescriptive authority. A physician assistant and an advanced
20 practice registered nurse are prohibited from prescribing
21 medications and controlled substances not set forth in the
22 required written delegation of authority or as authorized by
23 their practice Act.

24 (c) Upon completion of all registration requirements,
25 physician assistants, advanced practice registered nurses, and
26 animal euthanasia agencies may be issued a mid-level

1 practitioner controlled substances license for Illinois.

2 (d) A collaborating physician may, but is not required to,
3 delegate prescriptive authority to an advanced practice
4 registered nurse as part of a written collaborative agreement,
5 and the delegation of prescriptive authority shall conform to
6 the requirements of Section 65-40 of the Nurse Practice Act.

7 (e) A collaborating physician may, but is not required to,
8 delegate prescriptive authority to a physician assistant as
9 part of a written collaborative agreement, and the delegation
10 of prescriptive authority shall conform to the requirements of
11 Section 7.5 of the Physician Assistant Practice Act of 1987.

12 (f) Nothing in this Section shall be construed to prohibit
13 generic substitution.

14 (Source: P.A. 99-173, eff. 7-29-15; 100-453, eff. 8-25-17;
15 100-513, eff. 1-1-18; 100-863, eff. 8-14-18.)

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

23 Section 99. Effective date. This Act takes effect upon
24 becoming law.