

SB2943



104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB2943

Introduced 1/27/2026, by Sen. Adriane Johnson

SYNOPSIS AS INTRODUCED:

215 ILCS 5/356z.55
305 ILCS 5/5-5

Amends the Illinois Insurance Code. In provisions concerning coverage for cleft lip and cleft palate, provides that an individual or group policy of accident and health insurance amended, delivered, issued, or renewed on or after the effective date of the amendatory Act shall provide coverage for the medically necessary care and treatment of cleft lip and cleft palate for children or adults (instead of only for children under the age of 19). Amends the Medical Assistance Article of the Illinois Public Aid Code. Includes the care and treatment of cleft lip and cleft palate in provisions concerning coverage for dental services. Effective immediately.

LRB104 17357 BAB 30782 b

A BILL FOR

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 Illinois Insurance Code is amended by
5 changing Section 356z.55 as follows:

6 (215 ILCS 5/356z.55)

7 Sec. 356z.55. Coverage for cleft lip and cleft palate.

8 (a) As used in this Section, "medically necessary care and
9 treatment" to address congenital anomalies associated with a
10 cleft lip or palate, or both, includes:

11 (1) oral and facial surgery, including reconstructive
12 services and procedures necessary to improve and restore
13 and maintain vital functions;

14 (2) prosthetic treatment such as obturators, speech
15 appliances, and feeding appliances;

16 (3) orthodontic treatment and management;

17 (4) prosthodontic treatment and management; and

18 (5) otolaryngology treatment and management.

19 "Medically necessary care and treatment" does not include
20 cosmetic surgery performed to reshape normal structures of the
21 lip, jaw, palate, or other facial structures to improve
22 appearance.

23 (b) An individual or group policy of accident and health

1 insurance amended, delivered, issued, or renewed on or after
2 January 1, 2024 (the effective date of Public Act 102-768)
3 shall provide coverage for the medically necessary care and
4 treatment of cleft lip and palate for children under the age of
5 19.

6 An individual or group policy of accident and health
7 insurance amended, delivered, issued, or renewed on or after
8 the effective date of this amendatory Act of the 104th General
9 Assembly shall provide coverage for the medically necessary
10 care and treatment of cleft lip and cleft palate for children
11 or adults.

12 Coverage for cleft lip and palate care and treatment may
13 impose the same deductible, coinsurance, or other cost-sharing
14 limitation that is imposed on other related surgical benefits
15 under the policy.

16 (c) This Section does not apply to a policy that covers
17 only dental care.

18 (Source: P.A. 102-768, eff. 1-1-24; 103-154, eff. 6-30-23.)

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

21 (305 ILCS 5/5-5)

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

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

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

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

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

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

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

1 district's authority to establish, change, or administer a
2 school-based dental program in addition to, or independent of,
3 the school-based dental program administered by the
4 Department.

5 The Illinois Department, by rule, may distinguish and
6 classify the medical services to be provided only in
7 accordance with the classes of persons designated in Section
8 5-2.

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

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

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

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

25 (C) A mammogram at the age and intervals considered
26 medically necessary by the individual's health care

1 provider for individuals under 40 years of age and having
2 a family history of breast cancer, prior personal history
3 of breast cancer, positive genetic testing, or other risk
4 factors.

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

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

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

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

23 The Department shall not impose a deductible, coinsurance,
24 copayment, or any other cost-sharing requirement on the
25 coverage provided under this paragraph; except that this
26 sentence does not apply to coverage of diagnostic mammograms

1 to the extent such coverage would disqualify a high-deductible
2 health plan from eligibility for a health savings account
3 pursuant to Section 223 of the Internal Revenue Code (26
4 U.S.C. 223).

5 All screenings shall include a physical breast exam,
6 instruction on self-examination and information regarding the
7 frequency of self-examination and its value as a preventative
8 tool.

9 For purposes of this Section:

10 "Diagnostic mammogram" means a mammogram obtained using
11 diagnostic mammography.

12 "Diagnostic mammography" means a method of screening that
13 is designed to evaluate an abnormality in a breast, including
14 an abnormality seen or suspected on a screening mammogram or a
15 subjective or objective abnormality otherwise detected in the
16 breast.

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

24 "Breast tomosynthesis" means a radiologic procedure that
25 involves the acquisition of projection images over the
26 stationary breast to produce cross-sectional digital

1 three-dimensional images of the breast.

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

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

23 On and after January 1, 2012, providers participating in a
24 quality improvement program approved by the Department shall
25 be reimbursed for screening and diagnostic mammography at the
26 same rate as the Medicare program's rates, including the

1 increased reimbursement for digital mammography and, after
2 January 1, 2023 (the effective date of Public Act 102-1018),
3 breast tomosynthesis.

4 The Department shall convene an expert panel including
5 representatives of hospitals, free-standing mammography
6 facilities, and doctors, including radiologists, to establish
7 quality standards for mammography.

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

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

22 Subject to federal approval, the Department shall
23 establish a rate methodology for mammography at federally
24 qualified health centers and other encounter-rate clinics.
25 These clinics or centers may also collaborate with other
26 hospital-based mammography facilities. By January 1, 2016, the

1 Department shall report to the General Assembly on the status
2 of the provision set forth in this paragraph.

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

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

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

1 Illinois, one site in central Illinois, and 4 sites within
2 metropolitan Chicago. An evaluation of the pilot program shall
3 be carried out measuring health outcomes and cost of care for
4 those served by the pilot program compared to similarly
5 situated patients who are not served by the pilot program.

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

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

25 On or after July 1, 2022, individuals who are otherwise
26 eligible for medical assistance under this Article shall

1 receive coverage for perinatal depression screenings for the
2 12-month period beginning on the last day of their pregnancy.
3 Medical assistance coverage under this paragraph shall be
4 conditioned on the use of a screening instrument approved by
5 the Department.

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

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

25 The Illinois Department, in cooperation with the
26 Departments of Human Services (as successor to the Department

1 of Alcoholism and Substance Abuse) and Public Health, through
2 a public awareness campaign, may provide information
3 concerning treatment for alcoholism and drug abuse and
4 addiction, prenatal health care, and other pertinent programs
5 directed at reducing the number of drug-affected infants born
6 to recipients of medical assistance.

7 Neither the Department of Healthcare and Family Services
8 nor the Department of Human Services shall sanction the
9 recipient solely on the basis of the recipient's substance
10 abuse.

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

20 The Illinois Department may develop and contract with
21 Partnerships of medical providers to arrange medical services
22 for persons eligible under Section 5-2 of this Code.
23 Implementation of this Section may be by demonstration
24 projects in certain geographic areas. The Partnership shall be
25 represented by a sponsor organization. The Department, by
26 rule, shall develop qualifications for sponsors of

1 Partnerships. Nothing in this Section shall be construed to
2 require that the sponsor organization be a medical
3 organization.

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

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

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

22 (3) Persons receiving medical services through
23 Partnerships may receive medical and case management
24 services above the level usually offered through the
25 medical assistance program.

26 Medical providers shall be required to meet certain

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

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

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

21 The Illinois Department shall require health care
22 providers to maintain records that document the medical care
23 and services provided to recipients of Medical Assistance
24 under this Article. Such records must be retained for a period
25 of not less than 6 years from the date of service or as
26 provided by applicable State law, whichever period is longer,

1 except that if an audit is initiated within the required
2 retention period then the records must be retained until the
3 audit is completed and every exception is resolved. The
4 Illinois Department shall require health care providers to
5 make available, when authorized by the patient, in writing,
6 the medical records in a timely fashion to other health care
7 providers who are treating or serving persons eligible for
8 Medical Assistance under this Article. All dispensers of
9 medical services shall be required to maintain and retain
10 business and professional records sufficient to fully and
11 accurately document the nature, scope, details and receipt of
12 the health care provided to persons eligible for medical
13 assistance under this Code, in accordance with regulations
14 promulgated by the Illinois Department. The rules and
15 regulations shall require that proof of the receipt of
16 prescription drugs, dentures, prosthetic devices and
17 eyeglasses by eligible persons under this Section accompany
18 each claim for reimbursement submitted by the dispenser of
19 such medical services. No such claims for reimbursement shall
20 be approved for payment by the Illinois Department without
21 such proof of receipt, unless the Illinois Department shall
22 have put into effect and shall be operating a system of
23 post-payment audit and review which shall, on a sampling
24 basis, be deemed adequate by the Illinois Department to assure
25 that such drugs, dentures, prosthetic devices and eyeglasses
26 for which payment is being made are actually being received by

1 eligible recipients. Within 90 days after September 16, 1984
2 (the effective date of Public Act 83-1439), the Illinois
3 Department shall establish a current list of acquisition costs
4 for all prosthetic devices and any other items recognized as
5 medical equipment and supplies reimbursable under this Article
6 and shall update such list on a quarterly basis, except that
7 the acquisition costs of all prescription drugs shall be
8 updated no less frequently than every 30 days as required by
9 Section 5-5.12.

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

21 Notwithstanding any other law to the contrary, the
22 Illinois Department shall, within 365 days after August 15,
23 2014 (the effective date of Public Act 98-963), establish
24 procedures to permit ID/DD facilities licensed under the ID/DD
25 Community Care Act and MC/DD facilities licensed under the
26 MC/DD Act to submit monthly billing claims for reimbursement

1 purposes. Following development of these procedures, the
2 Department shall have an additional 365 days to test the
3 viability of the new system and to ensure that any necessary
4 operational or structural changes to its information
5 technology platforms are implemented.

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

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

23 Enrollment of a vendor shall be subject to a provisional
24 period and shall be conditional for one year. During the
25 period of conditional enrollment, the Department may terminate
26 the vendor's eligibility to participate in, or may disenroll

1 the vendor from, the medical assistance program without cause.
2 Unless otherwise specified, such termination of eligibility or
3 disenrollment is not subject to the Department's hearing
4 process. However, a disenrolled vendor may reapply without
5 penalty.

6 The Department has the discretion to limit the conditional
7 enrollment period for vendors based upon the category of risk
8 of the vendor.

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

21 The Department shall define or specify the following: (i)
22 by provider notice, the "category of risk of the vendor" for
23 each type of vendor, which shall take into account the level of
24 screening applicable to a particular category of vendor under
25 federal law and regulations; (ii) by rule or provider notice,
26 the maximum length of the conditional enrollment period for

1 each category of risk of the vendor; and (iii) by rule, the
2 hearing rights, if any, afforded to a vendor in each category
3 of risk of the vendor that is terminated or disenrolled during
4 the conditional enrollment period.

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

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

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

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

24 (4) In the case of a provider operated by a unit of
25 local government with a population exceeding 3,000,000
26 when local government funds finance federal participation

1 for claims payments.

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

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

24 Claims that are not submitted and received in compliance
25 with the foregoing requirements shall not be eligible for
26 payment under the medical assistance program, and the State

1 shall have no liability for payment of those claims.

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

16 The Illinois Department shall enter into agreements with
17 State agencies and departments, and is authorized to enter
18 into agreements with federal agencies and departments, under
19 which such agencies and departments shall share data necessary
20 for medical assistance program integrity functions and
21 oversight. The Illinois Department shall develop, in
22 cooperation with other State departments and agencies, and in
23 compliance with applicable federal laws and regulations,
24 appropriate and effective methods to share such data. At a
25 minimum, and to the extent necessary to provide data sharing,
26 the Illinois Department shall enter into agreements with State

1 agencies and departments, and is authorized to enter into
2 agreements with federal agencies and departments, including,
3 but not limited to: the Secretary of State; the Department of
4 Revenue; the Department of Public Health; the Department of
5 Human Services; and the Department of Financial and
6 Professional Regulation.

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

21 The Illinois Department shall establish policies,
22 procedures, standards and criteria by rule for the
23 acquisition, repair and replacement of orthotic and prosthetic
24 devices and durable medical equipment. Such rules shall
25 provide, but not be limited to, the following services: (1)
26 immediate repair or replacement of such devices by recipients;

1 and (2) rental, lease, purchase or lease-purchase of durable
2 medical equipment in a cost-effective manner, taking into
3 consideration the recipient's medical prognosis, the extent of
4 the recipient's needs, and the requirements and costs for
5 maintaining such equipment. Subject to prior approval, such
6 rules shall enable a recipient to temporarily acquire and use
7 alternative or substitute devices or equipment pending repairs
8 or replacements of any device or equipment previously
9 authorized for such recipient by the Department.
10 Notwithstanding any provision of Section 5-5f to the contrary,
11 the Department may, by rule, exempt certain replacement
12 wheelchair parts from prior approval and, for wheelchairs,
13 wheelchair parts, wheelchair accessories, and related seating
14 and positioning items, determine the wholesale price by
15 methods other than actual acquisition costs.

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

24 In order to promote environmental responsibility, meet the
25 needs of recipients and enrollees, and achieve significant
26 cost savings, the Department, or a managed care organization

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

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

1 institutional and home and community-based long term care
2 interests. This Section shall not restrict the Department from
3 implementing lower level of care eligibility criteria for
4 community-based services in circumstances where federal
5 approval has been granted.

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

13 The Illinois Department shall report annually to the
14 General Assembly, no later than the second Friday in April of
15 1979 and each year thereafter, in regard to:

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

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

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

22 (d) efforts at utilization review and control by the
23 Illinois Department.

24 The period covered by each report shall be the 3 years
25 ending on the June 30 prior to the report. The report shall
26 include suggested legislation for consideration by the General

1 Assembly. The requirement for reporting to the General
2 Assembly shall be satisfied by filing copies of the report as
3 required by Section 3.1 of the General Assembly Organization
4 Act, and filing such additional copies with the State
5 Government Report Distribution Center for the General Assembly
6 as is required under paragraph (t) of Section 7 of the State
7 Library Act.

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

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

19 Because kidney transplantation can be an appropriate,
20 cost-effective alternative to renal dialysis when medically
21 necessary and notwithstanding the provisions of Section 1-11
22 of this Code, beginning October 1, 2014, the Department shall
23 cover kidney transplantation for noncitizens with end-stage
24 renal disease who are not eligible for comprehensive medical
25 benefits, who meet the residency requirements of Section 5-3
26 of this Code, and who would otherwise meet the financial

1 requirements of the appropriate class of eligible persons
2 under Section 5-2 of this Code. To qualify for coverage of
3 kidney transplantation, such person must be receiving
4 emergency renal dialysis services covered by the Department.
5 Providers under this Section shall be prior approved and
6 certified by the Department to perform kidney transplantation
7 and the services under this Section shall be limited to
8 services associated with kidney transplantation.

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

21 On or after July 1, 2015, opioid antagonists prescribed
22 for the treatment of an opioid overdose, including the
23 medication product, administration devices, and any pharmacy
24 fees or hospital fees related to the dispensing, distribution,
25 and administration of the opioid antagonist, shall be covered
26 under the medical assistance program for persons who are

1 otherwise eligible for medical assistance under this Article.
2 As used in this Section, "opioid antagonist" means a drug that
3 binds to opioid receptors and blocks or inhibits the effect of
4 opioids acting on those receptors, including, but not limited
5 to, naloxone hydrochloride or any other similarly acting drug
6 approved by the U.S. Food and Drug Administration. The
7 Department shall not impose a copayment on the coverage
8 provided for naloxone hydrochloride under the medical
9 assistance program.

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

22 A federally qualified health center, as defined in Section
23 1905(1)(2)(B) of the federal Social Security Act, shall be
24 reimbursed by the Department in accordance with the federally
25 qualified health center's encounter rate for services provided
26 to medical assistance recipients that are performed by a

1 dental hygienist, as defined under the Illinois Dental
2 Practice Act, working under the general supervision of a
3 dentist and employed by a federally qualified health center.

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

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

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

1 Notwithstanding any other provision of this Code, within
2 12 months after June 2, 2022 (the effective date of Public Act
3 102-1037) and subject to federal approval, acupuncture
4 services performed by an acupuncturist licensed under the
5 Acupuncture Practice Act who is acting within the scope of his
6 or her license shall be covered under the medical assistance
7 program. The Department shall apply for any federal waiver or
8 State Plan amendment, if required, to implement this
9 paragraph. The Department may adopt any rules, including
10 standards and criteria, necessary to implement this paragraph.

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

1 Department of Public Health.

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

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

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

22 (Source: P.A. 103-102, Article 15, Section 15-5, eff. 1-1-24;
23 103-102, Article 95, Section 95-15, eff. 1-1-24; 103-123, eff.
24 1-1-24; 103-154, eff. 6-30-23; 103-368, eff. 1-1-24; 103-593,
25 Article 5, Section 5-5, eff. 6-7-24; 103-593, Article 90,
26 Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24; 103-808, eff.

1 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff. 8-9-24; 104-9,
2 eff. 6-16-25; 104-417, eff. 8-15-25.)

3 Section 99. Effective date. This Act takes effect upon
4 becoming law.