

1 AN ACT concerning public code.

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

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

6 (305 ILCS 5/5-5)

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the person may select.

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

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

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

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

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

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

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

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

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

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

1 formula is medically necessary.

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

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

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

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

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

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

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

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

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

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

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

21 For purposes of this Section:

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

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

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

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

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

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

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

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

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

16 The Department shall convene an expert panel including
17 representatives of hospitals, free-standing mammography
18 facilities, and doctors, including radiologists, to establish
19 quality standards for mammography.

20 On and after January 1, 2017, providers participating in a
21 breast cancer treatment quality improvement program approved
22 by the Department shall be reimbursed for breast cancer
23 treatment at a rate that is no lower than 95% of the Medicare
24 program's rates for the data elements included in the breast
25 cancer treatment quality program.

26 The Department shall convene an expert panel, including

1 representatives of hospitals, free-standing breast cancer
2 treatment centers, breast cancer quality organizations, and
3 doctors, including radiologists that are trained in all forms
4 of FDA-approved breast imaging technologies, breast surgeons,
5 reconstructive breast surgeons, oncologists, and primary care
6 providers to establish quality standards for breast cancer
7 treatment.

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

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

24 The Department shall establish a performance goal for
25 primary care providers with respect to their female patients
26 over age 40 receiving an annual mammogram. This performance

1 goal shall be used to provide additional reimbursement in the
2 form of a quality performance bonus to primary care providers
3 who meet that goal.

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

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

26 The Department shall provide coverage and reimbursement

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

11 On or after July 1, 2022, individuals who are otherwise
12 eligible for medical assistance under this Article shall
13 receive coverage for perinatal depression screenings for the
14 12-month period beginning on the last day of their pregnancy.
15 Medical assistance coverage under this paragraph shall be
16 conditioned on the use of a screening instrument approved by
17 the Department.

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

1 addiction for pregnant recipients in accordance with the
2 Illinois Medicaid Program in conjunction with the Department
3 of Human Services.

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

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

19 Neither the Department of Healthcare and Family Services
20 nor the Department of Human Services shall sanction the
21 recipient solely on the basis of the recipient's substance
22 abuse.

23 The Illinois Department shall establish such regulations
24 governing the dispensing of health services under this Article
25 as it shall deem appropriate. The Department should seek the
26 advice of formal professional advisory committees appointed by

1 the Director of the Illinois Department for the purpose of
2 providing regular advice on policy and administrative matters,
3 information dissemination and educational activities for
4 medical and health care providers, and consistency in
5 procedures to the Illinois Department.

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

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

26 (1) Physicians participating in a Partnership and

1 providing certain services, which shall be determined by
2 the Illinois Department, to persons in areas covered by
3 the Partnership may receive an additional surcharge for
4 such services.

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

8 (3) Persons receiving medical services through
9 Partnerships may receive medical and case management
10 services above the level usually offered through the
11 medical assistance program.

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

21 Nothing in this Section shall limit the free choice of
22 practitioners, hospitals, and other providers of medical
23 services by clients. In order to ensure patient freedom of
24 choice, the Illinois Department shall immediately promulgate
25 all rules and take all other necessary actions so that
26 provided services may be accessed from therapeutically

1 certified optometrists to the full extent of the Illinois
2 Optometric Practice Act of 1987 without discriminating between
3 service providers.

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

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

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

22 Notwithstanding any other law to the contrary, the
23 Illinois Department shall, within 365 days after July 22, 2013
24 (the effective date of Public Act 98-104), establish
25 procedures to permit skilled care facilities licensed under
26 the Nursing Home Care Act to submit monthly billing claims for

1 reimbursement purposes. Following development of these
2 procedures, the Department shall, by July 1, 2016, test the
3 viability of the new system and implement any necessary
4 operational or structural changes to its information
5 technology platforms in order to allow for the direct
6 acceptance and payment of nursing home claims.

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

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

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

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

18 The Department has the discretion to limit the conditional
19 enrollment period for vendors based upon the category of risk
20 of the vendor.

21 Prior to enrollment and during the conditional enrollment
22 period in the medical assistance program, all vendors shall be
23 subject to enhanced oversight, screening, and review based on
24 the risk of fraud, waste, and abuse that is posed by the
25 category of risk of the vendor. The Illinois Department shall
26 establish the procedures for oversight, screening, and review,

1 which may include, but need not be limited to: criminal and
2 financial background checks; fingerprinting; license,
3 certification, and authorization verifications; unscheduled or
4 unannounced site visits; database checks; prepayment audit
5 reviews; audits; payment caps; payment suspensions; and other
6 screening as required by federal or State law.

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

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

24 (1) In the case of a provider whose enrollment is in
25 process by the Illinois Department, the 180-day period
26 shall not begin until the date on the written notice from

1 the Illinois Department that the provider enrollment is
2 complete.

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

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

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

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

21 In the case of long term care facilities, within 120
22 calendar days of receipt by the facility of required
23 prescreening information, new admissions with associated
24 admission documents shall be submitted through the Medical
25 Electronic Data Interchange (MEDI) or the Recipient
26 Eligibility Verification (REV) System or shall be submitted

1 directly to the Department of Human Services using required
2 admission forms. Effective September 1, 2014, admission
3 documents, including all prescreening information, must be
4 submitted through MEDI or REV. Confirmation numbers assigned
5 to an accepted transaction shall be retained by a facility to
6 verify timely submittal. Once an admission transaction has
7 been completed, all resubmitted claims following prior
8 rejection are subject to receipt no later than 180 days after
9 the admission transaction has been completed.

10 Claims that are not submitted and received in compliance
11 with the foregoing requirements shall not be eligible for
12 payment under the medical assistance program, and the State
13 shall have no liability for payment of those claims.

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

1 corporate information; and death records.

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

19 Beginning in fiscal year 2013, the Illinois Department
20 shall set forth a request for information to identify the
21 benefits of a pre-payment, post-adjudication, and post-edit
22 claims system with the goals of streamlining claims processing
23 and provider reimbursement, reducing the number of pending or
24 rejected claims, and helping to ensure a more transparent
25 adjudication process through the utilization of: (i) provider
26 data verification and provider screening technology; and (ii)

1 clinical code editing; and (iii) pre-pay, pre-adjudicated, or
2 post-adjudicated predictive modeling with an integrated case
3 management system with link analysis. Such a request for
4 information shall not be considered as a request for proposal
5 or as an obligation on the part of the Illinois Department to
6 take any action or acquire any products or services.

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

1 methods other than actual acquisition costs.

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

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

1 federal Food and Drug Administration regulations and guidance
2 governing the reprocessing of medical devices in health care
3 settings; and (v) equally meets the needs of the recipient or
4 enrollee. The reutilization program shall confirm that the
5 recipient or enrollee is not already in receipt of the same or
6 similar equipment from another service provider, and that the
7 refurbished durable medical equipment equally meets the needs
8 of the recipient or enrollee. Nothing in this paragraph shall
9 be construed to limit recipient or enrollee choice to obtain
10 new durable medical equipment or place any additional prior
11 authorization conditions on enrollees of managed care
12 organizations.

13 The Department shall execute, relative to the nursing home
14 prescreening project, written inter-agency agreements with the
15 Department of Human Services and the Department on Aging, to
16 effect the following: (i) intake procedures and common
17 eligibility criteria for those persons who are receiving
18 non-institutional services; and (ii) the establishment and
19 development of non-institutional services in areas of the
20 State where they are not currently available or are
21 undeveloped; and (iii) notwithstanding any other provision of
22 law, subject to federal approval, on and after July 1, 2012, an
23 increase in the determination of need (DON) scores from 29 to
24 37 for applicants for institutional and home and
25 community-based long term care; if and only if federal
26 approval is not granted, the Department may, in conjunction

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

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

25 The Illinois Department shall report annually to the
26 General Assembly, no later than the second Friday in April of

1 1979 and each year thereafter, in regard to:

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

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

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

8 (d) efforts at utilization review and control by the
9 Illinois Department.

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

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

26 On and after July 1, 2012, the Department shall reduce any

1 rate of reimbursement for services or other payments or alter
2 any methodologies authorized by this Code to reduce any rate
3 of reimbursement for services or other payments in accordance
4 with Section 5-5e.

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

21 Notwithstanding any other provision of this Code to the
22 contrary, on or after July 1, 2015, all FDA-approved forms of
23 medication assisted treatment prescribed for the treatment of
24 alcohol dependence or treatment of opioid dependence shall be
25 covered under both fee-for-service and managed care medical
26 assistance programs for persons who are otherwise eligible for

1 medical assistance under this Article and shall not be subject
2 to any (1) utilization control, other than those established
3 under the American Society of Addiction Medicine patient
4 placement criteria, (2) prior authorization mandate, (3)
5 lifetime restriction limit mandate, or (4) limitations on
6 dosage.

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

22 Upon federal approval, the Department shall provide
23 coverage and reimbursement for all drugs that are approved for
24 marketing by the federal Food and Drug Administration and that
25 are recommended by the federal Public Health Service or the
26 United States Centers for Disease Control and Prevention for

1 pre-exposure prophylaxis and related pre-exposure prophylaxis
2 services, including, but not limited to, HIV and sexually
3 transmitted infection screening, treatment for sexually
4 transmitted infections, medical monitoring, assorted labs, and
5 counseling to reduce the likelihood of HIV infection among
6 individuals who are not infected with HIV but who are at high
7 risk of HIV infection.

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

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

23 Subject to approval by the federal Centers for Medicare
24 and Medicaid Services of a Title XIX State Plan amendment
25 electing the Program of All-Inclusive Care for the Elderly
26 (PACE) as a State Medicaid option, as provided for by Subtitle

1 I (commencing with Section 4801) of Title IV of the Balanced
2 Budget Act of 1997 (Public Law 105-33) and Part 460
3 (commencing with Section 460.2) of Subchapter E of Title 42 of
4 the Code of Federal Regulations, PACE program services shall
5 become a covered benefit of the medical assistance program,
6 subject to criteria established in accordance with all
7 applicable laws.

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

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

23 Notwithstanding any other provision of this Code, the
24 medical assistance program shall, subject to federal approval,
25 reimburse hospitals for costs associated with a newborn
26 screening test for the presence of metachromatic

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

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

22 Notwithstanding any other provision of this Code,
23 medically necessary reconstructive services that are intended
24 to restore physical appearance shall be covered under the
25 medical assistance program for persons who are otherwise
26 eligible for medical assistance under this Article. As used in

1 this paragraph, "reconstructive services" means treatments
2 performed on structures of the body damaged by trauma to
3 restore physical appearance.

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

8 (Source: P.A. 103-102, Article 15, Section 15-5, eff. 1-1-24;
9 103-102, Article 95, Section 95-15, eff. 1-1-24; 103-123, eff.
10 1-1-24; 103-154, eff. 6-30-23; 103-368, eff. 1-1-24; 103-593,
11 Article 5, Section 5-5, eff. 6-7-24; 103-593, Article 90,
12 Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24; 103-808, eff.
13 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff. 8-9-24; 104-9,
14 eff. 6-16-25; 104-417, eff. 8-15-25.)

15 Section 99. Effective date. This Act takes effect July 1,
16 2026.