



## 104TH GENERAL ASSEMBLY

### State of Illinois

2025 and 2026

HB1456

Introduced 1/28/2025, by Rep. Christopher "C.D." Davidsmeyer and Tony M. McCombie

#### SYNOPSIS AS INTRODUCED:

5 ILCS 100/5-45.37 rep.

305 ILCS 5/5-2

305 ILCS 5/5-5

305 ILCS 5/12-4.35

from Ch. 23, par. 5-2

Amends the Medical Assistance Article and the Administration Article of the Illinois Public Aid Code. Removes a provision requiring the Department of Healthcare and Family Services to cover kidney transplantation services for noncitizens under the medical assistance program. Removes provisions permitting the Department to provide medical services to noncitizens 42 years of age and older. Removes a provision requiring the Department to cover immunosuppressive drugs and related services associated with post kidney transplant management for noncitizens. Removes provisions concerning the adoption of emergency rules and other matters regarding medical coverage or services for noncitizens.

LRB104 07779 KTG 17824 b

1 AN ACT concerning public aid.

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

4 (5 ILCS 100/5-45.37 rep.)

5 Section 5. The Illinois Administrative Procedure Act is  
6 amended by repealing Section 5-45.37.

7 Section 10. The Illinois Public Aid Code is amended by  
8 changing Sections 5-2, 5-5, and 12-4.35 as follows:

9 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

10 Sec. 5-2. Classes of persons eligible. Medical assistance  
11 under this Article shall be available to any of the following  
12 classes of persons in respect to whom a plan for coverage has  
13 been submitted to the Governor by the Illinois Department and  
14 approved by him. If changes made in this Section 5-2 require  
15 federal approval, they shall not take effect until such  
16 approval has been received:

17 1. Recipients of basic maintenance grants under  
18 Articles III and IV.

19 2. Beginning January 1, 2014, persons otherwise  
20 eligible for basic maintenance under Article III,  
21 excluding any eligibility requirements that are  
22 inconsistent with any federal law or federal regulation,

1 as interpreted by the U.S. Department of Health and Human  
2 Services, but who fail to qualify thereunder on the basis  
3 of need, and who have insufficient income and resources to  
4 meet the costs of necessary medical care, including, but  
5 not limited to, the following:

6 (a) All persons otherwise eligible for basic  
7 maintenance under Article III but who fail to qualify  
8 under that Article on the basis of need and who meet  
9 either of the following requirements:

10 (i) their income, as determined by the  
11 Illinois Department in accordance with any federal  
12 requirements, is equal to or less than 100% of the  
13 federal poverty level; or

14 (ii) their income, after the deduction of  
15 costs incurred for medical care and for other  
16 types of remedial care, is equal to or less than  
17 100% of the federal poverty level.

18 (b) (Blank).

19 3. (Blank).

20 4. Persons not eligible under any of the preceding  
21 paragraphs who fall sick, are injured, or die, not having  
22 sufficient money, property or other resources to meet the  
23 costs of necessary medical care or funeral and burial  
24 expenses.

25 5.(a) Beginning January 1, 2020, individuals during  
26 pregnancy and during the 12-month period beginning on the

1 last day of the pregnancy, together with their infants,  
2 whose income is at or below 200% of the federal poverty  
3 level. Until September 30, 2019, or sooner if the  
4 maintenance of effort requirements under the Patient  
5 Protection and Affordable Care Act are eliminated or may  
6 be waived before then, individuals during pregnancy and  
7 during the 12-month period beginning on the last day of  
8 the pregnancy, whose countable monthly income, after the  
9 deduction of costs incurred for medical care and for other  
10 types of remedial care as specified in administrative  
11 rule, is equal to or less than the Medical Assistance-No  
12 Grant(C) (MANG(C)) Income Standard in effect on April 1,  
13 2013 as set forth in administrative rule.

14 (b) The plan for coverage shall provide ambulatory  
15 prenatal care to pregnant individuals during a presumptive  
16 eligibility period and establish an income eligibility  
17 standard that is equal to 200% of the federal poverty  
18 level, provided that costs incurred for medical care are  
19 not taken into account in determining such income  
20 eligibility.

21 (c) The Illinois Department may conduct a  
22 demonstration in at least one county that will provide  
23 medical assistance to pregnant individuals together with  
24 their infants and children up to one year of age, where the  
25 income eligibility standard is set up to 185% of the  
26 nonfarm income official poverty line, as defined by the

1 federal Office of Management and Budget. The Illinois  
2 Department shall seek and obtain necessary authorization  
3 provided under federal law to implement such a  
4 demonstration. Such demonstration may establish resource  
5 standards that are not more restrictive than those  
6 established under Article IV of this Code.

7 6. (a) Subject to federal approval, children younger  
8 than age 19 when countable income is at or below 313% of  
9 the federal poverty level, as determined by the Department  
10 and in accordance with all applicable federal  
11 requirements. The Department is authorized to adopt  
12 emergency rules to implement the changes made to this  
13 paragraph by Public Act 102-43. Until September 30, 2019,  
14 or sooner if the maintenance of effort requirements under  
15 the Patient Protection and Affordable Care Act are  
16 eliminated or may be waived before then, children younger  
17 than age 19 whose countable monthly income, after the  
18 deduction of costs incurred for medical care and for other  
19 types of remedial care as specified in administrative  
20 rule, is equal to or less than the Medical Assistance-No  
21 Grant(C) (MANG(C)) Income Standard in effect on April 1,  
22 2013 as set forth in administrative rule.

23 (b) Children and youth who are under temporary custody  
24 or guardianship of the Department of Children and Family  
25 Services or who receive financial assistance in support of  
26 an adoption or guardianship placement from the Department

1 of Children and Family Services.

2 7. (Blank).

3 8. As required under federal law, persons who are  
4 eligible for Transitional Medical Assistance as a result  
5 of an increase in earnings or child or spousal support  
6 received. The plan for coverage for this class of persons  
7 shall:

8 (a) extend the medical assistance coverage to the  
9 extent required by federal law; and

10 (b) offer persons who have initially received 6  
11 months of the coverage provided in paragraph (a)  
12 above, the option of receiving an additional 6 months  
13 of coverage, subject to the following:

14 (i) such coverage shall be pursuant to  
15 provisions of the federal Social Security Act;

16 (ii) such coverage shall include all services  
17 covered under Illinois' State Medicaid Plan;

18 (iii) no premium shall be charged for such  
19 coverage; and

20 (iv) such coverage shall be suspended in the  
21 event of a person's failure without good cause to  
22 file in a timely fashion reports required for this  
23 coverage under the Social Security Act and  
24 coverage shall be reinstated upon the filing of  
25 such reports if the person remains otherwise  
26 eligible.

1           9. Persons with acquired immunodeficiency syndrome  
2           (AIDS) or with AIDS-related conditions with respect to  
3           whom there has been a determination that but for home or  
4           community-based services such individuals would require  
5           the level of care provided in an inpatient hospital,  
6           skilled nursing facility or intermediate care facility the  
7           cost of which is reimbursed under this Article. Assistance  
8           shall be provided to such persons to the maximum extent  
9           permitted under Title XIX of the Federal Social Security  
10          Act.

11          10. Participants in the long-term care insurance  
12          partnership program established under the Illinois  
13          Long-Term Care Partnership Program Act who meet the  
14          qualifications for protection of resources described in  
15          Section 15 of that Act.

16          11. Persons with disabilities who are employed and  
17          eligible for Medicaid, pursuant to Section  
18          1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,  
19          subject to federal approval, persons with a medically  
20          improved disability who are employed and eligible for  
21          Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of  
22          the Social Security Act, as provided by the Illinois  
23          Department by rule. In establishing eligibility standards  
24          under this paragraph 11, the Department shall, subject to  
25          federal approval:

26                 (a) set the income eligibility standard at not

1 lower than 350% of the federal poverty level;

2 (b) exempt retirement accounts that the person  
3 cannot access without penalty before the age of 59  
4 1/2, and medical savings accounts established pursuant  
5 to 26 U.S.C. 220;

6 (c) allow non-exempt assets up to \$25,000 as to  
7 those assets accumulated during periods of eligibility  
8 under this paragraph 11; and

9 (d) continue to apply subparagraphs (b) and (c) in  
10 determining the eligibility of the person under this  
11 Article even if the person loses eligibility under  
12 this paragraph 11.

13 12. Subject to federal approval, persons who are  
14 eligible for medical assistance coverage under applicable  
15 provisions of the federal Social Security Act and the  
16 federal Breast and Cervical Cancer Prevention and  
17 Treatment Act of 2000. Those eligible persons are defined  
18 to include, but not be limited to, the following persons:

19 (1) persons who have been screened for breast or  
20 cervical cancer under the U.S. Centers for Disease  
21 Control and Prevention Breast and Cervical Cancer  
22 Program established under Title XV of the federal  
23 Public Health Service Act in accordance with the  
24 requirements of Section 1504 of that Act as  
25 administered by the Illinois Department of Public  
26 Health; and



1           (2) persons whose screenings under the above  
2 program were funded in whole or in part by funds  
3 appropriated to the Illinois Department of Public  
4 Health for breast or cervical cancer screening.

5           "Medical assistance" under this paragraph 12 shall be  
6 identical to the benefits provided under the State's  
7 approved plan under Title XIX of the Social Security Act.  
8 The Department must request federal approval of the  
9 coverage under this paragraph 12 within 30 days after July  
10 3, 2001 (the effective date of Public Act 92-47).

11           In addition to the persons who are eligible for  
12 medical assistance pursuant to subparagraphs (1) and (2)  
13 of this paragraph 12, and to be paid from funds  
14 appropriated to the Department for its medical programs,  
15 any uninsured person as defined by the Department in rules  
16 residing in Illinois who is younger than 65 years of age,  
17 who has been screened for breast and cervical cancer in  
18 accordance with standards and procedures adopted by the  
19 Department of Public Health for screening, and who is  
20 referred to the Department by the Department of Public  
21 Health as being in need of treatment for breast or  
22 cervical cancer is eligible for medical assistance  
23 benefits that are consistent with the benefits provided to  
24 those persons described in subparagraphs (1) and (2).  
25 Medical assistance coverage for the persons who are  
26 eligible under the preceding sentence is not dependent on

1 federal approval, but federal moneys may be used to pay  
2 for services provided under that coverage upon federal  
3 approval.

4 13. Subject to appropriation and to federal approval,  
5 persons living with HIV/AIDS who are not otherwise  
6 eligible under this Article and who qualify for services  
7 covered under Section 5-5.04 as provided by the Illinois  
8 Department by rule.

9 14. Subject to the availability of funds for this  
10 purpose, the Department may provide coverage under this  
11 Article to persons who reside in Illinois who are not  
12 eligible under any of the preceding paragraphs and who  
13 meet the income guidelines of paragraph 2(a) of this  
14 Section and (i) have an application for asylum pending  
15 before the federal Department of Homeland Security or on  
16 appeal before a court of competent jurisdiction and are  
17 represented either by counsel or by an advocate accredited  
18 by the federal Department of Homeland Security and  
19 employed by a not-for-profit organization in regard to  
20 that application or appeal, or (ii) are receiving services  
21 through a federally funded torture treatment center.  
22 Medical coverage under this paragraph 14 may be provided  
23 for up to 24 continuous months from the initial  
24 eligibility date so long as an individual continues to  
25 satisfy the criteria of this paragraph 14. If an  
26 individual has an appeal pending regarding an application

1 for asylum before the Department of Homeland Security,  
2 eligibility under this paragraph 14 may be extended until  
3 a final decision is rendered on the appeal. The Department  
4 may adopt rules governing the implementation of this  
5 paragraph 14.

6 15. Family Care Eligibility.

7 (a) On and after July 1, 2012, a parent or other  
8 caretaker relative who is 19 years of age or older when  
9 countable income is at or below 133% of the federal  
10 poverty level. A person may not spend down to become  
11 eligible under this paragraph 15.

12 (b) Eligibility shall be reviewed annually.

13 (c) (Blank).

14 (d) (Blank).

15 (e) (Blank).

16 (f) (Blank).

17 (g) (Blank).

18 (h) (Blank).

19 (i) Following termination of an individual's  
20 coverage under this paragraph 15, the individual must  
21 be determined eligible before the person can be  
22 re-enrolled.

23 16. Subject to appropriation, uninsured persons who  
24 are not otherwise eligible under this Section who have  
25 been certified and referred by the Department of Public  
26 Health as having been screened and found to need

1 diagnostic evaluation or treatment, or both diagnostic  
2 evaluation and treatment, for prostate or testicular  
3 cancer. For the purposes of this paragraph 16, uninsured  
4 persons are those who do not have creditable coverage, as  
5 defined under the Health Insurance Portability and  
6 Accountability Act, or have otherwise exhausted any  
7 insurance benefits they may have had, for prostate or  
8 testicular cancer diagnostic evaluation or treatment, or  
9 both diagnostic evaluation and treatment. To be eligible,  
10 a person must furnish a Social Security number. A person's  
11 assets are exempt from consideration in determining  
12 eligibility under this paragraph 16. Such persons shall be  
13 eligible for medical assistance under this paragraph 16  
14 for so long as they need treatment for the cancer. A person  
15 shall be considered to need treatment if, in the opinion  
16 of the person's treating physician, the person requires  
17 therapy directed toward cure or palliation of prostate or  
18 testicular cancer, including recurrent metastatic cancer  
19 that is a known or presumed complication of prostate or  
20 testicular cancer and complications resulting from the  
21 treatment modalities themselves. Persons who require only  
22 routine monitoring services are not considered to need  
23 treatment. "Medical assistance" under this paragraph 16  
24 shall be identical to the benefits provided under the  
25 State's approved plan under Title XIX of the Social  
26 Security Act. Notwithstanding any other provision of law,

1 the Department (i) does not have a claim against the  
2 estate of a deceased recipient of services under this  
3 paragraph 16 and (ii) does not have a lien against any  
4 homestead property or other legal or equitable real  
5 property interest owned by a recipient of services under  
6 this paragraph 16.

7 17. Persons who, pursuant to a waiver approved by the  
8 Secretary of the U.S. Department of Health and Human  
9 Services, are eligible for medical assistance under Title  
10 XIX or XXI of the federal Social Security Act.  
11 Notwithstanding any other provision of this Code and  
12 consistent with the terms of the approved waiver, the  
13 Illinois Department, may by rule:

14 (a) Limit the geographic areas in which the waiver  
15 program operates.

16 (b) Determine the scope, quantity, duration, and  
17 quality, and the rate and method of reimbursement, of  
18 the medical services to be provided, which may differ  
19 from those for other classes of persons eligible for  
20 assistance under this Article.

21 (c) Restrict the persons' freedom in choice of  
22 providers.

23 18. Beginning January 1, 2014, persons aged 19 or  
24 older, but younger than 65, who are not otherwise eligible  
25 for medical assistance under this Section 5-2, who qualify  
26 for medical assistance pursuant to 42 U.S.C.

1           1396a(a)(10)(A)(i)(VIII) and applicable federal  
2 regulations, and who have income at or below 133% of the  
3 federal poverty level plus 5% for the applicable family  
4 size as determined pursuant to 42 U.S.C. 1396a(e)(14) and  
5 applicable federal regulations. Persons eligible for  
6 medical assistance under this paragraph 18 shall receive  
7 coverage for the Health Benefits Service Package as that  
8 term is defined in subsection (m) of Section 5-1.1 of this  
9 Code. If Illinois' federal medical assistance percentage  
10 (FMAP) is reduced below 90% for persons eligible for  
11 medical assistance under this paragraph 18, eligibility  
12 under this paragraph 18 shall cease no later than the end  
13 of the third month following the month in which the  
14 reduction in FMAP takes effect.

15           19. Beginning January 1, 2014, as required under 42  
16 U.S.C. 1396a(a)(10)(A)(i)(IX), persons older than age 18  
17 and younger than age 26 who are not otherwise eligible for  
18 medical assistance under paragraphs (1) through (17) of  
19 this Section who (i) were in foster care under the  
20 responsibility of the State on the date of attaining age  
21 18 or on the date of attaining age 21 when a court has  
22 continued wardship for good cause as provided in Section  
23 2-31 of the Juvenile Court Act of 1987 and (ii) received  
24 medical assistance under the Illinois Title XIX State Plan  
25 or waiver of such plan while in foster care.

26           20. Beginning January 1, 2018, persons who are

1 foreign-born victims of human trafficking, torture, or  
2 other serious crimes as defined in Section 2-19 of this  
3 Code and their derivative family members if such persons:  
4 (i) reside in Illinois; (ii) are not eligible under any of  
5 the preceding paragraphs; (iii) meet the income guidelines  
6 of subparagraph (a) of paragraph 2; and (iv) meet the  
7 nonfinancial eligibility requirements of Sections 16-2,  
8 16-3, and 16-5 of this Code. The Department may extend  
9 medical assistance for persons who are foreign-born  
10 victims of human trafficking, torture, or other serious  
11 crimes whose medical assistance would be terminated  
12 pursuant to subsection (b) of Section 16-5 if the  
13 Department determines that the person, during the year of  
14 initial eligibility (1) experienced a health crisis, (2)  
15 has been unable, after reasonable attempts, to obtain  
16 necessary information from a third party, or (3) has other  
17 extenuating circumstances that prevented the person from  
18 completing his or her application for status. The  
19 Department may adopt any rules necessary to implement the  
20 provisions of this paragraph.

21 21. (Blank). ~~Persons who are not otherwise eligible~~  
22 ~~for medical assistance under this Section who may qualify~~  
23 ~~for medical assistance pursuant to 42 U.S.C.~~  
24 ~~1396a(a)(10)(A)(ii)(XXIII) and 42 U.S.C. 1396(ss) for the~~  
25 ~~duration of any federal or State declared emergency due to~~  
26 ~~COVID 19. Medical assistance to persons eligible for~~

1 ~~medical assistance solely pursuant to this paragraph 21~~  
2 ~~shall be limited to any in vitro diagnostic product (and~~  
3 ~~the administration of such product) described in 42 U.S.C.~~  
4 ~~1396d(a)(3)(B) on or after March 18, 2020, any visit~~  
5 ~~described in 42 U.S.C. 1396o(a)(2)(G), or any other~~  
6 ~~medical assistance that may be federally authorized for~~  
7 ~~this class of persons. The Department may also cover~~  
8 ~~treatment of COVID 19 for this class of persons, or any~~  
9 ~~similar category of uninsured individuals, to the extent~~  
10 ~~authorized under a federally approved 1115 Waiver or other~~  
11 ~~federal authority. Notwithstanding the provisions of~~  
12 ~~Section 1-11 of this Code, due to the nature of the~~  
13 ~~COVID-19 public health emergency, the Department may cover~~  
14 ~~and provide the medical assistance described in this~~  
15 ~~paragraph 21 to noncitizens who would otherwise meet the~~  
16 ~~eligibility requirements for the class of persons~~  
17 ~~described in this paragraph 21 for the duration of the~~  
18 ~~State emergency period.~~

19 In implementing the provisions of Public Act 96-20, the  
20 Department is authorized to adopt only those rules necessary,  
21 including emergency rules. Nothing in Public Act 96-20 permits  
22 the Department to adopt rules or issue a decision that expands  
23 eligibility for the FamilyCare Program to a person whose  
24 income exceeds 185% of the Federal Poverty Level as determined  
25 from time to time by the U.S. Department of Health and Human  
26 Services, unless the Department is provided with express



1 statutory authority.

2 The eligibility of any such person for medical assistance  
3 under this Article is not affected by the payment of any grant  
4 under the Senior Citizens and Persons with Disabilities  
5 Property Tax Relief Act or any distributions or items of  
6 income described under subparagraph (X) of paragraph (2) of  
7 subsection (a) of Section 203 of the Illinois Income Tax Act.

8 The Department shall by rule establish the amounts of  
9 assets to be disregarded in determining eligibility for  
10 medical assistance, which shall at a minimum equal the amounts  
11 to be disregarded under the Federal Supplemental Security  
12 Income Program. The amount of assets of a single person to be  
13 disregarded shall not be less than \$2,000, and the amount of  
14 assets of a married couple to be disregarded shall not be less  
15 than \$3,000.

16 To the extent permitted under federal law, any person  
17 found guilty of a second violation of Article VIIIA shall be  
18 ineligible for medical assistance under this Article, as  
19 provided in Section 8A-8.

20 The eligibility of any person for medical assistance under  
21 this Article shall not be affected by the receipt by the person  
22 of donations or benefits from fundraisers held for the person  
23 in cases of serious illness, as long as neither the person nor  
24 members of the person's family have actual control over the  
25 donations or benefits or the disbursement of the donations or  
26 benefits.

1           Notwithstanding any other provision of this Code, if the  
2 United States Supreme Court holds Title II, Subtitle A,  
3 Section 2001(a) of Public Law 111-148 to be unconstitutional,  
4 or if a holding of Public Law 111-148 makes Medicaid  
5 eligibility allowed under Section 2001(a) inoperable, the  
6 State or a unit of local government shall be prohibited from  
7 enrolling individuals in the Medical Assistance Program as the  
8 result of federal approval of a State Medicaid waiver on or  
9 after June 14, 2012 (the effective date of Public Act 97-687),  
10 and any individuals enrolled in the Medical Assistance Program  
11 pursuant to eligibility permitted as a result of such a State  
12 Medicaid waiver shall become immediately ineligible.

13           Notwithstanding any other provision of this Code, if an  
14 Act of Congress that becomes a Public Law eliminates Section  
15 2001(a) of Public Law 111-148, the State or a unit of local  
16 government shall be prohibited from enrolling individuals in  
17 the Medical Assistance Program as the result of federal  
18 approval of a State Medicaid waiver on or after June 14, 2012  
19 (the effective date of Public Act 97-687), and any individuals  
20 enrolled in the Medical Assistance Program pursuant to  
21 eligibility permitted as a result of such a State Medicaid  
22 waiver shall become immediately ineligible.

23           Effective October 1, 2013, the determination of  
24 eligibility of persons who qualify under paragraphs 5, 6, 8,  
25 15, 17, and 18 of this Section shall comply with the  
26 requirements of 42 U.S.C. 1396a(e)(14) and applicable federal

1 regulations.

2 The Department of Healthcare and Family Services, the  
3 Department of Human Services, and the Illinois health  
4 insurance marketplace shall work cooperatively to assist  
5 persons who would otherwise lose health benefits as a result  
6 of changes made under Public Act 98-104 to transition to other  
7 health insurance coverage.

8 (Source: P.A. 101-10, eff. 6-5-19; 101-649, eff. 7-7-20;  
9 102-43, eff. 7-6-21; 102-558, eff. 8-20-21; 102-665, eff.  
10 10-8-21; 102-813, eff. 5-13-22.)

11 (305 ILCS 5/5-5)

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

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

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

1 discover evidence which may be used in criminal proceedings  
2 arising from the sexual assault; (16) the diagnosis and  
3 treatment of sickle cell anemia; (16.5) services performed by  
4 a chiropractic physician licensed under the Medical Practice  
5 Act of 1987 and acting within the scope of his or her license,  
6 including, but not limited to, chiropractic manipulative  
7 treatment; and (17) any other medical care, and any other type  
8 of remedial care recognized under the laws of this State. The  
9 term "any other type of remedial care" shall include nursing  
10 care and nursing home service for persons who rely on  
11 treatment by spiritual means alone through prayer for healing.

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

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

24 Notwithstanding any other provision of this Section, all  
25 tobacco cessation medications approved by the United States  
26 Food and Drug Administration and all individual and group

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

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

1 documentation.

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

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

26             (1) dental services provided by or under the

1 supervision of a dentist; and

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

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

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

26 Subject to federal approval, on and after January 1, 2025,



1 the rates paid for sedation evaluation and the provision of  
2 deep sedation and intravenous sedation for the purpose of  
3 dental services shall be increased by 33% above the rates in  
4 effect on December 31, 2024. The rates paid for nitrous oxide  
5 sedation shall not be impacted by this paragraph and shall  
6 remain the same as the rates in effect on December 31, 2024.

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

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

24 On and after January 1, 2022, the Department of Healthcare  
25 and Family Services shall administer and regulate a  
26 school-based dental program that allows for the out-of-office

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

20 The Illinois Department, by rule, may distinguish and  
21 classify the medical services to be provided only in  
22 accordance with the classes of persons designated in Section  
23 5-2.

24 The Department of Healthcare and Family Services must  
25 provide coverage and reimbursement for amino acid-based  
26 elemental formulas, regardless of delivery method, for the

1 diagnosis and treatment of (i) eosinophilic disorders and (ii)  
2 short bowel syndrome when the prescribing physician has issued  
3 a written order stating that the amino acid-based elemental  
4 formula is medically necessary.

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

10 (A) A baseline mammogram for individuals 35 to 39  
11 years of age.

12 (B) An annual mammogram for individuals 40 years of  
13 age or older.

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

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

25 (E) A screening MRI when medically necessary, as  
26 determined by a physician licensed to practice medicine in

1 all of its branches.

2 (F) A diagnostic mammogram when medically necessary,  
3 as determined by a physician licensed to practice medicine  
4 in all its branches, advanced practice registered nurse,  
5 or physician assistant.

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

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

18 For purposes of this Section:

19 "Diagnostic mammogram" means a mammogram obtained using  
20 diagnostic mammography.

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

26 "Low-dose mammography" means the x-ray examination of the

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

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

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

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

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

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

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

23           The Department shall convene an expert panel, including  
24 representatives of hospitals, free-standing breast cancer  
25 treatment centers, breast cancer quality organizations, and  
26 doctors, including breast surgeons, reconstructive breast

1 surgeons, oncologists, and primary care providers to establish  
2 quality standards for breast cancer treatment.

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

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

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

25 The Department shall devise a means of case-managing or  
26 patient navigation for beneficiaries diagnosed with breast

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

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

21 The Department shall provide coverage and reimbursement  
22 for a human papillomavirus (HPV) vaccine that is approved for  
23 marketing by the federal Food and Drug Administration for all  
24 persons between the ages of 9 and 45. Subject to federal  
25 approval, the Department shall provide coverage and  
26 reimbursement for a human papillomavirus (HPV) vaccine for



1 persons of the age of 46 and above who have been diagnosed with  
2 cervical dysplasia with a high risk of recurrence or  
3 progression. The Department shall disallow any  
4 preauthorization requirements for the administration of the  
5 human papillomavirus (HPV) vaccine.

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

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

25 All medical providers providing medical assistance to  
26 pregnant individuals under this Code shall receive information

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

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

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

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

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

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

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

26           (2) The Department may elect to consider and negotiate

1 financial incentives to encourage the development of  
2 Partnerships and the efficient delivery of medical care.

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

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

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

25 The Department shall apply for a waiver from the United  
26 States Health Care Financing Administration to allow for the

1 implementation of Partnerships under this Section.

2 The Illinois Department shall require health care  
3 providers to maintain records that document the medical care  
4 and services provided to recipients of Medical Assistance  
5 under this Article. Such records must be retained for a period  
6 of not less than 6 years from the date of service or as  
7 provided by applicable State law, whichever period is longer,  
8 except that if an audit is initiated within the required  
9 retention period then the records must be retained until the  
10 audit is completed and every exception is resolved. The  
11 Illinois Department shall require health care providers to  
12 make available, when authorized by the patient, in writing,  
13 the medical records in a timely fashion to other health care  
14 providers who are treating or serving persons eligible for  
15 Medical Assistance under this Article. All dispensers of  
16 medical services shall be required to maintain and retain  
17 business and professional records sufficient to fully and  
18 accurately document the nature, scope, details and receipt of  
19 the health care provided to persons eligible for medical  
20 assistance under this Code, in accordance with regulations  
21 promulgated by the Illinois Department. The rules and  
22 regulations shall require that proof of the receipt of  
23 prescription drugs, dentures, prosthetic devices and  
24 eyeglasses by eligible persons under this Section accompany  
25 each claim for reimbursement submitted by the dispenser of  
26 such medical services. No such claims for reimbursement shall

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

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

1 acceptance and payment of nursing home claims.

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

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

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

1 regarding medical bills paid by the Illinois Department, which  
2 inquiries could indicate potential existence of claims or  
3 liens for the Illinois Department.

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

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

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



1 screening as required by federal or State law.

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

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

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

24 (2) In the case of errors attributable to the Illinois  
25 Department or any of its claims processing intermediaries  
26 which result in an inability to receive, process, or

1 adjudicate a claim, the 180-day period shall not begin  
2 until the provider has been notified of the error.

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

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

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

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

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

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

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

23 The Illinois Department shall enter into agreements with  
24 State agencies and departments, and is authorized to enter  
25 into agreements with federal agencies and departments, under  
26 which such agencies and departments shall share data necessary

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

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

1 take any action or acquire any products or services.

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

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

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

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

1 similar equipment from another service provider, and that the  
2 refurbished durable medical equipment equally meets the needs  
3 of the recipient or enrollee. Nothing in this paragraph shall  
4 be construed to limit recipient or enrollee choice to obtain  
5 new durable medical equipment or place any additional prior  
6 authorization conditions on enrollees of managed care  
7 organizations.

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

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

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

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

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

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



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

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

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

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

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

26 ~~Because kidney transplantation can be an appropriate,~~

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

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

1 limitations on dosage.

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

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

1 individuals who are not infected with HIV but who are at high  
2 risk of HIV infection.

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

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

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

1 subject to criteria established in accordance with all  
2 applicable laws.

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

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

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

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

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

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

26 (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;

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

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

14 Sec. 5-5. Medical services. The Illinois Department, by  
15 rule, shall determine the quantity and quality of and the rate  
16 of reimbursement for the medical assistance for which payment  
17 will be authorized, and the medical services to be provided,  
18 which may include all or part of the following: (1) inpatient  
19 hospital services; (2) outpatient hospital services; (3) other  
20 laboratory and X-ray services; (4) skilled nursing home  
21 services; (5) physicians' services whether furnished in the  
22 office, the patient's home, a hospital, a skilled nursing  
23 home, or elsewhere; (6) medical care, or any other type of  
24 remedial care furnished by licensed practitioners; (7) home  
25 health care services; (8) private duty nursing service; (9)

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



1 sexual assault, including examinations and laboratory tests to  
2 discover evidence which may be used in criminal proceedings  
3 arising from the sexual assault; (16) the diagnosis and  
4 treatment of sickle cell anemia; (16.5) services performed by  
5 a chiropractic physician licensed under the Medical Practice  
6 Act of 1987 and acting within the scope of his or her license,  
7 including, but not limited to, chiropractic manipulative  
8 treatment; and (17) any other medical care, and any other type  
9 of remedial care recognized under the laws of this State. The  
10 term "any other type of remedial care" shall include nursing  
11 care and nursing home service for persons who rely on  
12 treatment by spiritual means alone through prayer for healing.

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

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

25 Notwithstanding any other provision of this Section, all  
26 tobacco cessation medications approved by the United States

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

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

1 other appropriate requirements regarding laboratory test order  
2 documentation.

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

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

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

3           (2) eyeglasses prescribed by a physician skilled in  
4 the diseases of the eye, or by an optometrist, whichever  
5 the person may select.

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

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

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

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

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

25           On and after January 1, 2022, the Department of Healthcare  
26 and Family Services shall administer and regulate a

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

21 The Illinois Department, by rule, may distinguish and  
22 classify the medical services to be provided only in  
23 accordance with the classes of persons designated in Section  
24 5-2.

25 The Department of Healthcare and Family Services must  
26 provide coverage and reimbursement for amino acid-based

1 elemental formulas, regardless of delivery method, for the  
2 diagnosis and treatment of (i) eosinophilic disorders and (ii)  
3 short bowel syndrome when the prescribing physician has issued  
4 a written order stating that the amino acid-based elemental  
5 formula is medically necessary.

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

11 (A) A baseline mammogram for individuals 35 to 39  
12 years of age.

13 (B) An annual mammogram for individuals 40 years of  
14 age or older.

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

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

26 (E) A screening MRI when medically necessary, as

1           determined by a physician licensed to practice medicine in  
2           all of its branches.

3           (F) A diagnostic mammogram when medically necessary,  
4           as determined by a physician licensed to practice medicine  
5           in all its branches, advanced practice registered nurse,  
6           or physician assistant.

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

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

21          All screenings shall include a physical breast exam,  
22          instruction on self-examination and information regarding the  
23          frequency of self-examination and its value as a preventative  
24          tool.

25          For purposes of this Section:

26          "Diagnostic mammogram" means a mammogram obtained using



1 diagnostic mammography.

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

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

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

18 If, at any time, the Secretary of the United States  
19 Department of Health and Human Services, or its successor  
20 agency, promulgates rules or regulations to be published in  
21 the Federal Register or publishes a comment in the Federal  
22 Register or issues an opinion, guidance, or other action that  
23 would require the State, pursuant to any provision of the  
24 Patient Protection and Affordable Care Act (Public Law  
25 111-148), including, but not limited to, 42 U.S.C.  
26 18031(d)(3)(B) or any successor provision, to defray the cost

1 of any coverage for breast tomosynthesis outlined in this  
2 paragraph, then the requirement that an insurer cover breast  
3 tomosynthesis is inoperative other than any such coverage  
4 authorized under Section 1902 of the Social Security Act, 42  
5 U.S.C. 1396a, and the State shall not assume any obligation  
6 for the cost of coverage for breast tomosynthesis set forth in  
7 this paragraph.

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

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

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

24 On and after January 1, 2017, providers participating in a  
25 breast cancer treatment quality improvement program approved  
26 by the Department shall be reimbursed for breast cancer

1 treatment at a rate that is no lower than 95% of the Medicare  
2 program's rates for the data elements included in the breast  
3 cancer treatment quality program.

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

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

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

1 evaluation.

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

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

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

1 access for patients diagnosed with cancer to at least one  
2 academic commission on cancer-accredited cancer program as an  
3 in-network covered benefit.

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

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

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

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

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

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

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

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

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

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

1 medical services delivered by Partnership providers to clients  
2 in target areas according to provisions of this Article and  
3 the Illinois Health Finance Reform Act, except that:

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

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

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

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

25 Nothing in this Section shall limit the free choice of  
26 practitioners, hospitals, and other providers of medical



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

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

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

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

26 Notwithstanding any other law to the contrary, the

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

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

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

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

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

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

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

25 Prior to enrollment and during the conditional enrollment  
26 period in the medical assistance program, all vendors shall be

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

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

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

1 exceptions:

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

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

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

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

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

25 In the case of long term care facilities, within 120  
26 calendar days of receipt by the facility of required

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

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

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

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

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

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



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

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

1 the Department may, by rule, exempt certain replacement  
2 wheelchair parts from prior approval and, for wheelchairs,  
3 wheelchair parts, wheelchair accessories, and related seating  
4 and positioning items, determine the wholesale price by  
5 methods other than actual acquisition costs.

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

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

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

17 The Department shall execute, relative to the nursing home  
18 prescreening project, written inter-agency agreements with the  
19 Department of Human Services and the Department on Aging, to  
20 effect the following: (i) intake procedures and common  
21 eligibility criteria for those persons who are receiving  
22 non-institutional services; and (ii) the establishment and  
23 development of non-institutional services in areas of the  
24 State where they are not currently available or are  
25 undeveloped; and (iii) notwithstanding any other provision of  
26 law, subject to federal approval, on and after July 1, 2012, an

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

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

1 services and facilities, as it affects persons eligible for  
2 medical assistance under this Code.

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

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

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

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

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

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

24 Rulemaking authority to implement Public Act 95-1045, if  
25 any, is conditioned on the rules being adopted in accordance  
26 with all provisions of the Illinois Administrative Procedure

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

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

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

25 Notwithstanding any other provision of this Code to the  
26 contrary, on or after July 1, 2015, all FDA-approved ~~FDA~~

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

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

26 Upon federal approval, the Department shall provide

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

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

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



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

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

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

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

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

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

9           (Source: P.A. 102-43, Article 30, Section 30-5, eff. 7-6-21;  
10 102-43, Article 35, Section 35-5, eff. 7-6-21; 102-43, Article  
11 55, Section 55-5, eff. 7-6-21; 102-95, eff. 1-1-22; 102-123,  
12 eff. 1-1-22; 102-558, eff. 8-20-21; 102-598, eff. 1-1-22;  
13 102-655, eff. 1-1-22; 102-665, eff. 10-8-21; 102-813, eff.  
14 5-13-22; 102-1018, eff. 1-1-23; 102-1037, eff. 6-2-22;  
15 102-1038, eff. 1-1-23; 103-102, Article 15, Section 15-5, eff.  
16 1-1-24; 103-102, Article 95, Section 95-15, eff. 1-1-24;  
17 103-123, eff. 1-1-24; 103-154, eff. 6-30-23; 103-368, eff.  
18 1-1-24; 103-593, Article 5, Section 5-5, eff. 6-7-24; 103-593,  
19 Article 90, Section 90-5, eff. 6-7-24; 103-605, eff. 7-1-24;  
20 103-808, eff. 1-1-26; 103-909, eff. 8-9-24; 103-1040, eff.  
21 8-9-24; revised 10-10-24.)

22           (305 ILCS 5/12-4.35)

23           Sec. 12-4.35. Medical services for certain noncitizens.  
24 ~~(a)~~ Notwithstanding Section 1-11 of this Code or Section 20(a)  
25 of the Children's Health Insurance Program Act, the Department

1 of Healthcare and Family Services may provide medical services  
2 to noncitizens who have not yet attained 19 years of age and  
3 who are not eligible for medical assistance under Article V of  
4 this Code or under the Children's Health Insurance Program  
5 created by the Children's Health Insurance Program Act due to  
6 their not meeting the otherwise applicable provisions of  
7 Section 1-11 of this Code or Section 20(a) of the Children's  
8 Health Insurance Program Act. The medical services available,  
9 standards for eligibility, and other conditions of  
10 participation under this Section shall be established by rule  
11 by the Department; however, any such rule shall be at least as  
12 restrictive as the rules for medical assistance under Article  
13 V of this Code or the Children's Health Insurance Program  
14 created by the Children's Health Insurance Program Act.

15 ~~(a-5) Notwithstanding Section 1-11 of this Code, the~~  
16 ~~Department of Healthcare and Family Services may provide~~  
17 ~~medical assistance in accordance with Article V of this Code~~  
18 ~~to noncitizens over the age of 65 years of age who are not~~  
19 ~~eligible for medical assistance under Article V of this Code~~  
20 ~~due to their not meeting the otherwise applicable provisions~~  
21 ~~of Section 1-11 of this Code, whose income is at or below 100%~~  
22 ~~of the federal poverty level after deducting the costs of~~  
23 ~~medical or other remedial care, and who would otherwise meet~~  
24 ~~the eligibility requirements in Section 5-2 of this Code. The~~  
25 ~~medical services available, standards for eligibility, and~~  
26 ~~other conditions of participation under this Section shall be~~

1 ~~established by rule by the Department; however, any such rule~~  
2 ~~shall be at least as restrictive as the rules for medical~~  
3 ~~assistance under Article V of this Code.~~

4 ~~(a-6) By May 30, 2022, notwithstanding Section 1-11 of~~  
5 ~~this Code, the Department of Healthcare and Family Services~~  
6 ~~may provide medical services to noncitizens 55 years of age~~  
7 ~~through 64 years of age who (i) are not eligible for medical~~  
8 ~~assistance under Article V of this Code due to their not~~  
9 ~~meeting the otherwise applicable provisions of Section 1-11 of~~  
10 ~~this Code and (ii) have income at or below 133% of the federal~~  
11 ~~poverty level plus 5% for the applicable family size as~~  
12 ~~determined under applicable federal law and regulations.~~  
13 ~~Persons eligible for medical services under Public Act 102-16~~  
14 ~~shall receive benefits identical to the benefits provided~~  
15 ~~under the Health Benefits Service Package as that term is~~  
16 ~~defined in subsection (m) of Section 5-1.1 of this Code.~~

17 ~~(a-7) By July 1, 2022, notwithstanding Section 1-11 of~~  
18 ~~this Code, the Department of Healthcare and Family Services~~  
19 ~~may provide medical services to noncitizens 42 years of age~~  
20 ~~through 54 years of age who (i) are not eligible for medical~~  
21 ~~assistance under Article V of this Code due to their not~~  
22 ~~meeting the otherwise applicable provisions of Section 1-11 of~~  
23 ~~this Code and (ii) have income at or below 133% of the federal~~  
24 ~~poverty level plus 5% for the applicable family size as~~  
25 ~~determined under applicable federal law and regulations. The~~  
26 ~~medical services available, standards for eligibility, and~~

1 ~~other conditions of participation under this Section shall be~~  
2 ~~established by rule by the Department; however, any such rule~~  
3 ~~shall be at least as restrictive as the rules for medical~~  
4 ~~assistance under Article V of this Code. In order to provide~~  
5 ~~for the timely and expeditious implementation of this~~  
6 ~~subsection, the Department may adopt rules necessary to~~  
7 ~~establish and implement this subsection through the use of~~  
8 ~~emergency rulemaking in accordance with Section 5-45 of the~~  
9 ~~Illinois Administrative Procedure Act. For purposes of the~~  
10 ~~Illinois Administrative Procedure Act, the General Assembly~~  
11 ~~finds that the adoption of rules to implement this subsection~~  
12 ~~is deemed necessary for the public interest, safety, and~~  
13 ~~welfare.~~

14 ~~(a-10) Notwithstanding the provisions of Section 1-11, the~~  
15 ~~Department shall cover immunosuppressive drugs and related~~  
16 ~~services associated with post kidney transplant management,~~  
17 ~~excluding long term care costs, for noncitizens who: (i) are~~  
18 ~~not eligible for comprehensive medical benefits; (ii) meet the~~  
19 ~~residency requirements of Section 5-3; and (iii) would meet~~  
20 ~~the financial eligibility requirements of Section 5-2.~~

21 ~~(b) The Department is authorized to take any action that~~  
22 ~~would not otherwise be prohibited by applicable law,~~  
23 ~~including, without limitation, cessation or limitation of~~  
24 ~~enrollment, reduction of available medical services, and~~  
25 ~~changing standards for eligibility, that is deemed necessary~~  
26 ~~by the Department during a State fiscal year to assure that~~

1 ~~payments under this Section do not exceed available funds.~~

2 ~~(c) (Blank).~~

3 ~~(d) (Blank).~~

4 ~~(e) In order to provide for the expeditious and effective~~  
5 ~~ongoing implementation of this Section, the Department may~~  
6 ~~adopt rules through the use of emergency rulemaking in~~  
7 ~~accordance with Section 5-45 of the Illinois Administrative~~  
8 ~~Procedure Act, except that the limitation on the number of~~  
9 ~~emergency rules that may be adopted in a 24 month period shall~~  
10 ~~not apply. For purposes of the Illinois Administrative~~  
11 ~~Procedure Act, the General Assembly finds that the adoption of~~  
12 ~~rules to implement this Section is deemed necessary for the~~  
13 ~~public interest, safety, and welfare. This subsection (c) is~~  
14 ~~inoperative on and after July 1, 2025.~~

15 (Source: P.A. 102-16, eff. 6-17-21; 102-43, Article 25,  
16 Section 25-15, eff. 7-6-21; 102-43, Article 45, Section 45-5,  
17 eff. 7-6-21; 102-813, eff. 5-13-22; 102-1037, eff. 6-2-22;  
18 103-102, eff. 6-16-23.)

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