



103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB4901

Introduced 2/7/2024, by Rep. Natalie A. Manley

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-5

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that on and after January 1, 2025, the rates paid for sedation evaluation and the provision of deep sedation and intravenous sedation for the purpose of dental services shall be increased by 33% above the rates in effect on December 31, 2024. Provides that the rates paid for nitrous oxide sedation shall not be impacted by the amendatory Act and shall remain the same as the rates in effect on December 31, 2024. Effective January 1, 2025.

LRB103 36276 KTG 66373 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 Section 5. The Illinois Public Aid Code is amended by
5 changing Section 5-5 as follows:

6 (305 ILCS 5/5-5)

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

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

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

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

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

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

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

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

24 Upon receipt of federal approval of an amendment to the
25 Illinois Title XIX State Plan for this purpose, the Department
26 shall authorize the Chicago Public Schools (CPS) to procure a

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

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

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

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

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

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

22 On and after January 1, 2025, the rates paid for sedation
23 evaluation and the provision of deep sedation and intravenous
24 sedation for the purpose of dental services shall be increased
25 by 33% above the rates in effect on December 31, 2024. The
26 rates paid for nitrous oxide sedation shall not be impacted by

1 this paragraph and shall remain the same as the rates in effect
2 on December 31, 2024.

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

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

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

12 The Illinois Department, by rule, may distinguish and
13 classify the medical services to be provided only in
14 accordance with the classes of persons designated in Section
15 5-2.

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

23 The Illinois Department shall authorize the provision of,
24 and shall authorize payment for, screening by low-dose
25 mammography for the presence of occult breast cancer for
26 individuals 35 years of age or older who are eligible for

1 medical assistance under this Article, as follows:

2 (A) A baseline mammogram for individuals 35 to 39
3 years of age.

4 (B) An annual mammogram for individuals 40 years of
5 age or older.

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

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

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

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

24 The Department shall not impose a deductible, coinsurance,
25 copayment, or any other cost-sharing requirement on the
26 coverage provided under this paragraph; except that this

1 sentence does not apply to coverage of diagnostic mammograms
2 to the extent such coverage would disqualify a high-deductible
3 health plan from eligibility for a health savings account
4 pursuant to Section 223 of the Internal Revenue Code (26
5 U.S.C. 223).

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

10 For purposes of this Section:

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

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

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

25 "Breast tomosynthesis" means a radiologic procedure that
26 involves the acquisition of projection images over the

1 stationary breast to produce cross-sectional digital
2 three-dimensional images of the breast.

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

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

24 On and after January 1, 2012, providers participating in a
25 quality improvement program approved by the Department shall
26 be reimbursed for screening and diagnostic mammography at the

1 same rate as the Medicare program's rates, including the
2 increased reimbursement for digital mammography and, after
3 January 1, 2023 (the effective date of Public Act 102-1018),
4 breast tomosynthesis.

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

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

15 The Department shall convene an expert panel, including
16 representatives of hospitals, free-standing breast cancer
17 treatment centers, breast cancer quality organizations, and
18 doctors, including breast surgeons, reconstructive breast
19 surgeons, oncologists, and primary care providers to establish
20 quality standards for breast cancer treatment.

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

1 of the provision set forth in this paragraph.

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

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

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

1 metropolitan Chicago. An evaluation of the pilot program shall
2 be carried out measuring health outcomes and cost of care for
3 those served by the pilot program compared to similarly
4 situated patients who are not served by the pilot program.

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

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

24 On or after July 1, 2022, individuals who are otherwise
25 eligible for medical assistance under this Article shall
26 receive coverage for perinatal depression screenings for the

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

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

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

24 The Illinois Department, in cooperation with the
25 Departments of Human Services (as successor to the Department
26 of Alcoholism and Substance Abuse) and Public Health, through

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

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

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

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

1 require that the sponsor organization be a medical
2 organization.

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

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

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

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

25 Medical providers shall be required to meet certain
26 qualifications to participate in Partnerships to ensure the

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

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

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

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

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

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

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

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

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

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

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

22 Enrollment of a vendor shall be subject to a provisional
23 period and shall be conditional for one year. During the
24 period of conditional enrollment, the Department may terminate
25 the vendor's eligibility to participate in, or may disenroll
26 the vendor from, the medical assistance program without cause.

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

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

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

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

1 hearing rights, if any, afforded to a vendor in each category
2 of risk of the vendor that is terminated or disenrolled during
3 the conditional enrollment period.

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

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

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

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

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

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

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

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

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

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

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

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

20 The Illinois Department shall establish policies,
21 procedures, standards and criteria by rule for the
22 acquisition, repair and replacement of orthotic and prosthetic
23 devices and durable medical equipment. Such rules shall
24 provide, but not be limited to, the following services: (1)
25 immediate repair or replacement of such devices by recipients;
26 and (2) rental, lease, purchase or lease-purchase of durable

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

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

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

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

26 The Department shall execute, relative to the nursing home

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 On or after July 1, 2015, opioid antagonists prescribed
20 for the treatment of an opioid overdose, including the
21 medication product, administration devices, and any pharmacy
22 fees or hospital fees related to the dispensing, distribution,
23 and administration of the opioid antagonist, shall be covered
24 under the medical assistance program for persons who are
25 otherwise eligible for medical assistance under this Article.
26 As used in this Section, "opioid antagonist" means a drug that

1 binds to opioid receptors and blocks or inhibits the effect of
2 opioids acting on those receptors, including, but not limited
3 to, naloxone hydrochloride or any other similarly acting drug
4 approved by the U.S. Food and Drug Administration. The
5 Department shall not impose a copayment on the coverage
6 provided for naloxone hydrochloride under the medical
7 assistance program.

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

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

1 dentist and employed by a federally qualified health center.

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

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

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

25 Notwithstanding any other provision of this Code, within
26 12 months after June 2, 2022 (the effective date of Public Act

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

9 Notwithstanding any other provision of this Code, the
10 medical assistance program shall, subject to appropriation and
11 federal approval, reimburse hospitals for costs associated
12 with a newborn screening test for the presence of
13 metachromatic leukodystrophy, as required under the Newborn
14 Metabolic Screening 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; revised 12-15-23.)

19 Section 99. Effective date. This Act takes effect January
20 1, 2025.