SB3900

LRB10420577SSS34064b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

SB3900

Introduced 2/6/2026, by Sen. Lakesia Collins

SYNOPSIS AS INTRODUCED:

New Act	
5 ILCS 100/5-5	from Ch. 127, par. 1005-5
210 ILCS 85/6.25	
215 ILCS 5/370c	from Ch. 73, par. 982c
215 ILCS 125/4-2	from Ch. 111 1/2, par. 1408.2
305 ILCS 5/5-5	

Creates the Illinois All-Payer Health Care Payment and Global Budget Act. Creates the Illinois Health Care Cost and Payment Board as an independent body within the Department of Healthcare and Family Services and sets forth its membership and powers. Defines "commercial payer" as any health insurance issuer, health maintenance organization, or third-party administrator subject to regulation by the Illinois Department of Insurance, excluding self-funded plans governed solely by ERISA. Provides that all commercial payers shall reimburse hospitals for covered services at standardized rates established by the Board. Defines "global hospital budget" as a prospective, fixed annual operating revenue amount established for a hospital to cover all inpatient and outpatient hospital services. Provides that the Board shall establish prospective annual global hospital budgets for Illinois hospitals. Provides that the Board shall establish a unified health care data system in coordination with State agencies. Creates the Health Care Payment Reform Advisory Council to advise the Board. Provides that the Governor, in consultation with the Board, shall seek all necessary federal approvals, including Medicare demonstrations and Medicaid waivers, to implement the Act. Amends the Illinois Administrative Procedure Act, Hospital Licensing Act, Illinois Insurance Code, Health Maintenance Organization Act, and Illinois Public Aid Code with regard to the new Act. Contains a severability clause. Effective immediately.

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A BILL FOR

AN ACT concerning health.

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

Section 1. Short title. This Act may be cited as the Illinois All-Payer Health Care Payment and Global Budget Act.

Section 3. Legislative findings and purposes.

(a) The General Assembly finds that:

(1) Health care expenditures in Illinois continue to grow at a rate that is unsustainable for households, employers, and the State.

(2) Fragmented payment systems and differential reimbursement rates contribute to cost-shifting, administrative waste, and inequitable access to care.

(3) Hospitals and essential providers require predictable and stable financing to meet community health needs, particularly in rural and safety-net settings.

(4) States may, consistent with federal law and through approved waivers and demonstrations, align Medicare, Medicaid, and commercial payment systems.

(b) The purposes of this Act are to:

(1) Establish an all-payer health care payment system with standardized reimbursement rates across hospital systems;

(2) Implement prospective global hospital budgets that are decoupled from service volume;

(3) Control the growth of total health care expenditures while maintaining or improving quality, access, and equity;

(4) Reduce administrative burden and eliminate cost-shifting among payers; and

(5) Support a stable and sustainable health care workforce.

Section 5. Definitions. As used in this Act:

"All-payer payment system" means a system under which reimbursement rates and payment methodologies are standardized and applied uniformly across all participating payers.

"Board" means the Illinois Health Care Cost and Payment Board established under Section 10.

"Commercial payer" means any health insurance issuer, health maintenance organization, or third-party administrator subject to regulation by the Illinois Department of Insurance, excluding self-funded plans governed solely by ERISA.

"Global hospital budget" means a prospective, fixed annual operating revenue amount established for a hospital to cover all inpatient and outpatient hospital services.

"Hospital" means any facility licensed under the Hospital Licensing Act.

Section 10. Illinois Health Care Cost and Payment Board.

(a) The Illinois Health Care Cost and Payment Board is created as an independent body within the Department of Healthcare and Family Services.

(b) The Board shall consist of 9 members appointed by the Governor with the advice and consent of the Senate, including individuals with expertise in health economics, hospital administration, clinical care, labor, consumer advocacy, and health equity. No more than 4 members shall have current financial ties to health care entities regulated under this Act.

(c) The Board has the authority to:

(1) Establish and administer an all-payer payment system;

(2) Set standardized reimbursement rates and methodologies;

(3) Establish, approve, and enforce global hospital budgets;

(4) Set statewide total cost of care growth targets;

(5) Collect data and require reporting necessary to carry out this Act; and

(6) Enforce compliance through audits, corrective actions, and penalties.

Section 15. All-payer standardized reimbursement rates.

(a) Beginning January 1, 2027, all commercial payers shall

reimburse hospitals for covered services at standardized rates established by the Board.

(b) Standardized rates shall:

(1) Be based on a transparent benchmark, including the Medicare fee schedule or diagnosis-related group system;

(2) Apply uniformly across commercial payers for the same service within a defined geographic region;

(3) Include adjustments approved by the Board for:

(A) Patient acuity;

(B) Teaching status;

(C) Rural or safety-net designation; and

(D) Documented social risk factors.

(c) A commercial payer or hospital shall not charge, pay, or collect amounts in excess of the standardized rate.

(d) Nothing in this Section shall be construed to reduce covered benefits under Medicare or Medicaid. Medicaid participation shall be aligned through federal waivers or State plan amendments.

Section 20. Global hospital budgets.

(a) The Board shall establish prospective annual global hospital budgets for hospitals licensed in Illinois.

(b) Global hospital budgets shall:

(1) Cover all inpatient and outpatient hospital services;

(2) Be determined using:

(A) Historical utilization and spending;

(B) Community health needs assessments;

(C) Population size and demographics; and

(D) Quality, access, and equity performance; and

(3) Be adjusted annually for inflation, population change, and policy priorities.

(c) By State fiscal year 2028, the Board shall implement global hospital budgets for at least 5 hospitals representing diverse geographic regions.

(d) By State fiscal year 2031, all hospitals shall operate under global hospital budgets, except critical access hospitals, which may elect to participate.

(e) A hospital operating under a global budget shall not increase total annual revenue through increased service volume.

Section 25. Budget submission and review.

(a) Each hospital subject to this Act shall submit an annual budget proposal to the Board in a form prescribed by the Board.

(b) The Board shall review proposed budgets to ensure:

(1) Alignment with statewide total cost of care growth targets;

(2) Maintenance of access to essential services; and

(3) Compliance with quality and equity standards.

(c) The Board may approve, modify, or reject a proposed

budget after public notice and comment.

Section 30. Enforcement and penalties.

(a) The Board may conduct audits and require production of documents.

(b) For noncompliance, the Board may impose:

(1) Financial penalties;

(2) Budget reductions;

(3) Corrective action plans; and

(4) Referral to the Department of Insurance or the Attorney General.

Section 35. Data collection and transparency.

(a) The Board shall establish a unified health care data system in coordination with State agencies.

(b) Data shall be used to monitor:

(1) Total cost of care;

(2) Utilization and access; and

(3) Quality and equity outcomes.

Section 40. Health Care Payment Reform Advisory Council.

(a) A Health Care Payment Reform Advisory Council is created to advise the Board.

(b) Membership shall include representatives of hospitals, physicians, nurses, labor organizations, consumers, insurers, Medicaid managed care organizations, and rural providers.

Section 45. Federal waivers and alignment. The Governor, in consultation with the Board, shall seek all necessary federal approvals, including Medicare demonstrations and Medicaid waivers, to implement this Act.

Section 81. The Illinois Administrative Procedure Act is amended by changing Section 5-5 as follows:

(5 ILCS 100/5-5) (from Ch. 127, par. 1005-5)

Sec. 5-5. Applicability. All rules of agencies shall be adopted in accordance with this Article.

The Illinois Health Care Cost and Payment Board shall be exempt from rulemaking requirements under this Section for the establishment of initial standardized reimbursement rates and global hospital budgets; provided that subsequent revisions shall be subject to public notice and comment.

(Source: P.A. 87-823.)

Section 83. The Hospital Licensing Act is amended by changing Section 6.25 as follows:

(210 ILCS 85/6.25)

Sec. 6.25. Safe patient handling policy.

(a) In this Section:

"Health care worker" means an individual providing direct

patient care services who may be required to lift, transfer, reposition, or move a patient.

"Nurse" means an advanced practice registered nurse, a registered nurse, or a licensed practical nurse licensed under the Nurse Practice Act.

"Safe lifting equipment and accessories" means mechanical equipment designed to lift, move, reposition, and transfer patients, including, but not limited to, fixed and portable ceiling lifts, sit-to-stand lifts, slide sheets and boards, slings, and repositioning and turning sheets.

"Safe lifting team" means at least 2 individuals who are trained in the use of both safe lifting techniques and safe lifting equipment and accessories, including the responsibility for knowing the location and condition of such equipment and accessories.

(b) A hospital must adopt and ensure implementation of a policy to identify, assess, and develop strategies to control risk of injury to patients and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a patient. The policy shall establish a process that, at a minimum, includes all of the following:

(1) Analysis of the risk of injury to patients and nurses and other health care workers posted by the patient handling needs of the patient populations served by the hospital and the physical environment in which the patient

handling and movement occurs.

(2) Education and training of nurses and other direct patient care providers in the identification, assessment, and control of risks of injury to patients and nurses and other health care workers during patient handling and on safe lifting policies and techniques and current lifting equipment.

(3) Evaluation of alternative ways to reduce risks associated with patient handling, including evaluation of equipment and the environment.

(4) Restriction, to the extent feasible with existing equipment and aids, of manual patient handling or movement of all or most of a patient's weight except for emergency, life-threatening, or otherwise exceptional circumstances.

(5) Collaboration with and an annual report to the nurse staffing committee.

(6) Procedures for a nurse to refuse to perform or be involved in patient handling or movement that the nurse in good faith believes will expose a patient or nurse or other health care worker to an unacceptable risk of injury.

(7) Submission of an annual report to the hospital's governing body or quality assurance committee on activities related to the identification, assessment, and development of strategies to control risk of injury to patients and nurses and other health care workers

associated with the lifting, transferring, repositioning, or movement of a patient.

(8) In developing architectural plans for construction or remodeling of a hospital or unit of a hospital in which patient handling and movement occurs, consideration of the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment.

(9) Fostering and maintaining patient safety, dignity, self-determination, and choice, including the following policies, strategies, and procedures:

(A) the existence and availability of a trained safe lifting team;

(B) a policy of advising patients of a range of transfer and lift options, including adjustable diagnostic and treatment equipment, mechanical lifts, and provision of a trained safe lifting team;

(C) the right of a competent patient, or guardian of a patient adjudicated incompetent, to choose among the range of transfer and lift options, subject to the provisions of subparagraph (E) of this paragraph (9);

(D) procedures for documenting, upon admission and as status changes, a mobility assessment and plan for lifting, transferring, repositioning, or movement of a patient, including the choice of the patient or patient's guardian among the range of transfer and

lift options; and

(E) incorporation of such safe lifting procedures, techniques, and equipment as are consistent with applicable federal law.

(c) A hospital licensed under this Act that is subject to a global hospital budget established by the Illinois Health Care Cost and Payment Board shall operate in compliance with such budget as a condition of licensure.

(Source: P.A. 100-513, eff. 1-1-18.)

Section 85. The Illinois Insurance Code is amended by changing Section 370c as follows:

(215 ILCS 5/370c) (from Ch. 73, par. 982c)

Sec. 370c. Mental and emotional disorders.

(a)(1) On and after January 1, 2022 (the effective date of Public Act 102-579), every insurer that amends, delivers, issues, or renews group accident and health policies providing coverage for hospital or medical treatment or services for illness shall provide coverage for the medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions consistent with the parity requirements of Section 370c.1 of this Code.

(2) Each insured that is covered for mental, emotional, nervous, or substance use disorders or conditions shall be free to select the physician licensed to practice medicine in

all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act of his or her choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his or her profession.

(3) Insofar as this Section applies solely to licensed clinical social workers, licensed clinical professional counselors, licensed marriage and family therapists, licensed

speech-language pathologists, and other licensed or certified professionals at programs licensed pursuant to the Substance Use Disorder Act, those persons who may provide services to individuals shall do so after the licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, licensed speech-language pathologist, or other licensed or certified professional at a program licensed pursuant to the Substance Use Disorder Act has informed the patient of the desirability of the patient conferring with the patient's primary care physician.

(4) "Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the World Health Organization's International Classification of Disease or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. "Mental, emotional, nervous, or substance use disorder or condition" includes any mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

(5) Medically necessary treatment and medical necessity determinations shall be interpreted and made in a manner that is consistent with and pursuant to subsections (h) through

(y).

(b)(1) (Blank).

(2) (Blank).

(2.5) (Blank).

(3) Unless otherwise prohibited by federal law and consistent with the parity requirements of Section 370c.1 of this Code, the insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance, a qualified health plan offered through the health insurance marketplace, or a provider of treatment of mental, emotional, nervous, or substance use disorders or conditions shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. Nothing in this paragraph (3) supersedes the prohibition on prior authorization requirements to the extent provided under subsections (g) and (w) and subparagraph (A) of paragraph (6.5) of this subsection. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for mental, emotional, nervous, or substance use disorders or conditions, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. Medical necessity determinations for substance use

disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations for substance use disorders.

(4) A group health benefit plan amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024) or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall provide coverage based upon medical necessity for the treatment of a mental, emotional, nervous, or substance use disorder or condition consistent with the parity requirements of Section 370c.1 of this Code; provided, however, that in each calendar year coverage shall not be less than the following:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921), 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for delivery, renewed, or modified after January 1, 2007 (the effective date of Public Act 94-906), 20 additional outpatient visits for speech therapy for

treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A); and

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan.

(C) (Blank).

(5) An issuer of a group health benefit plan or an individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(5.5) An individual or group health benefit plan amended, delivered, issued, or renewed on or after September 9, 2015 (the effective date of Public Act 99-480) shall offer coverage for medically necessary acute treatment services and medically necessary clinical stabilization services. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations for substance use disorders in accordance with the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions

established by the American Society of Addiction Medicine. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations for medication-assisted treatment in accordance with the most current Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine.

As used in this subsection:

"Acute treatment services" means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

"Clinical stabilization services" means 24-hour treatment, usually following acute treatment services for substance abuse, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

"Prior authorization" has the meaning given to that term in Section 15 of the Prior Authorization Reform Act.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed care plan.

(6.5) An individual or group health benefit plan amended,

delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1024):

(A) shall not impose prior authorization requirements, including limitations on dosage, other than those established under the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine, on a prescription medication approved by the United States Food and Drug Administration that is prescribed or administered for the treatment of substance use disorders;

(B) shall not impose any step therapy requirements;

(C) shall place all prescription medications approved by the United States Food and Drug Administration prescribed or administered for the treatment of substance use disorders on, for brand medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers brand medications and, for generic medications, the lowest tier of the drug formulary developed and maintained by the individual or group health benefit plan that covers generic medications; and

(D) shall not exclude coverage for a prescription medication approved by the United States Food and Drug Administration for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services

were court ordered.

(7) (Blank).

(8) (Blank).

(9) With respect to all mental, emotional, nervous, or substance use disorders or conditions, coverage for inpatient treatment shall include coverage for treatment in a residential treatment center certified or licensed by the Department of Public Health or the Department of Human Services.

(c) This Section shall not be interpreted to require coverage for speech therapy or other habilitative services for those individuals covered under Section 356z.15 of this Code.

(d) With respect to a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace, the Department and, with respect to medical assistance, the Department of Healthcare and Family Services shall each enforce the requirements of this Section and Sections 356z.23 and 370c.1 of this Code, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any amendments to, and federal guidance or regulations issued under, those Acts, including, but not limited to, final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and final regulations applying the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity

Act of 2008 to Medicaid managed care organizations, the Children's Health Insurance Program, and alternative benefit plans. Specifically, the Department and the Department of Healthcare and Family Services shall take action:

(1) proactively ensuring compliance by individual and group policies, including by requiring that insurers submit comparative analyses, as set forth in paragraph (6) of subsection (k) of Section 370c.1, demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental, emotional, nervous, or substance use disorder or condition benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical and surgical benefits;

(2) evaluating all consumer or provider complaints regarding mental, emotional, nervous, or substance use disorder or condition coverage for possible parity violations;

(3) performing parity compliance market conduct examinations or, in the case of the Department of Healthcare and Family Services, parity compliance audits of individual and group plans and policies, including, but not limited to, reviews of:

(A) nonquantitative treatment limitations, including, but not limited to, prior authorization requirements, concurrent review, retrospective review,

step therapy, network admission standards, reimbursement rates, and geographic restrictions;

(B) denials of authorization, payment, and coverage; and

(C) other specific criteria as may be determined by the Department.

The findings and the conclusions of the parity compliance market conduct examinations and audits shall be made public.

The Director may adopt rules to effectuate any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

(e) Availability of plan information.

(1) The criteria for medical necessity determinations made under a group health plan, an individual policy of accident and health insurance, or a qualified health plan offered through the health insurance marketplace with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

(2) The reason for any denial under a group health benefit plan, an individual policy of accident and health

insurance, or a qualified health plan offered through the health insurance marketplace (or health insurance coverage offered in connection with such plan or policy) of reimbursement or payment for services with respect to mental, emotional, nervous, or substance use disorders or conditions benefits in the case of any participant or beneficiary must be made available within a reasonable time and in a reasonable manner and in readily understandable language by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary upon request.

(f) As used in this Section, "group policy of accident and health insurance" and "group health benefit plan" includes (1) State-regulated employer-sponsored group health insurance plans written in Illinois or which purport to provide coverage for a resident of this State; and (2) State, county, municipal, or school district employee health plans. References to an insurer include all plans described in this subsection.

(g) (1) As used in this subsection:

"Benefits", with respect to insurers that are not Medicaid managed care organizations, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (High-Intensity Outpatient), 3.1 (Clinically

Managed Low-Intensity Residential), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Managed Residential) and OMT (Opioid Maintenance Therapy) services.

"Benefits", with respect to Medicaid managed care organizations, means the benefits provided for treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (High-Intensity Outpatient), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Managed Residential) and OMT (Opioid Maintenance Therapy) services.

"Substance use disorder treatment provider or facility" means a licensed physician, licensed psychologist, licensed psychiatrist, licensed advanced practice registered nurse, or licensed, certified, or otherwise State-approved facility or provider of substance use disorder treatment.

(2) A group health insurance policy, an individual health benefit plan, or qualified health plan that is offered through the health insurance marketplace, small employer group health plan, and large employer group health plan that is amended, delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State, on or after January 1, 2019 (the effective date of Public Act 100-1023) shall comply with the requirements of this Section and Section 370c.1. The services for the treatment and the ongoing assessment of the patient's progress in treatment shall follow

the requirements of 77 Ill. Adm. Code 2060.

(3) Prior authorization shall not be utilized for the benefits under this subsection. Except to the extent prohibited by Section 370c.1 with respect to treatment limitations in a benefit classification or subclassification, the insurer may require the substance use disorder treatment provider or facility to notify the insurer of the initiation of treatment. For an insurer that is not a Medicaid managed care organization, the substance use disorder treatment provider or facility may be required to give notification for the initiation of treatment of the covered person within 2 business days. For Medicaid managed care organizations, the substance use disorder treatment provider or facility may be required to give notification in accordance with the protocol set forth in the provider agreement for initiation of treatment within 24 hours. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following admission, the substance use disorder treatment provider or facility shall have one additional business day to provide the notification to the appropriate managed care organization. Treatment plans shall be developed in accordance with the requirements and timeframes established in 77 Ill. Adm. Code 2060. No such coverage shall be subject to concurrent review prior to the applicable notification deadline. If coverage is denied retrospectively, neither the

provider or facility nor the insurer shall bill, and the covered individual shall not be liable, for any treatment under this subsection through the date the adverse determination is issued, other than any copayment, coinsurance, or deductible for the treatment or stay through that date as applicable under the policy. Coverage shall not be retrospectively denied for benefits that were furnished at a participating substance use disorder facility prior to the applicable notification deadline except for the following:

(A) upon reasonable determination that the benefits were not provided;

(B) upon determination that the patient receiving the treatment was not an insured, enrollee, or beneficiary under the policy;

(C) upon material misrepresentation by the patient or provider. As used in this subparagraph (C), "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation;

(D) upon determination that a service was excluded under the terms of coverage. For situations that qualify under this subparagraph (D), the limitation to billing for a copayment, coinsurance, or deductible shall not apply;

(E) upon determination that a service was not medically necessary consistent with subsections (h) through (n); or

(F) upon determination that the patient did not consent to the treatment and that there was no court order mandating the treatment.

(4) For an insurer that is not a Medicaid managed care organization, if an insurer determines that benefits are no longer medically necessary, the insurer shall notify the covered person, the covered person's authorized representative, if any, and the covered person's health care provider in writing of the covered person's right to request an external review pursuant to the Health Carrier External Review Act. The notification shall occur within 24 hours following the adverse determination.

Pursuant to the requirements of the Health Carrier External Review Act, the covered person or the covered person's authorized representative may request an expedited external review. An expedited external review may not occur if the substance use disorder treatment provider or facility determines that continued treatment is no longer medically necessary.

If an expedited external review request meets the criteria of the Health Carrier External Review Act, an independent review organization shall make a final determination of medical necessity within 72 hours. If an independent review organization upholds an adverse determination, an insurer shall remain responsible to provide coverage of benefits through the day following the determination of the independent

review organization. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act.

(5) The substance use disorder treatment provider or facility shall provide the insurer with 7 business days' advance notice of the planned discharge of the patient from the substance use disorder treatment provider or facility and notice on the day that the patient is discharged from the substance use disorder treatment provider or facility.

(6) The benefits required by this subsection shall be provided to all covered persons with a diagnosis of substance use disorder or conditions. The presence of additional related or unrelated diagnoses shall not be a basis to reduce or deny the benefits required by this subsection.

(7) Nothing in this subsection shall be construed to require an insurer to provide coverage for any of the benefits in this subsection.

(8) Any concurrent or retrospective review permitted by this subsection must be consistent with the utilization review provisions in subsections (h) through (n).

(h) As used in this Section:

"Generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical

sociology, social work, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

"Medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, or condition or its symptoms and comorbidities, including minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities in a manner that is all of the following:

(1) in accordance with the generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the economic benefit of the

insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

"Utilization review" means either of the following:

(1) prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services before, retrospectively, or concurrently with the provision of health care services to insureds.

(2) evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

"Utilization review criteria" means patient placement criteria or any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

(i)(1) Every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State and Medicaid managed care organizations providing coverage for hospital or medical treatment on or after January 1, 2023 shall, pursuant

to subsections (h) through (s), provide coverage for medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions.

(2) An insurer shall not set a specific limit on the duration of benefits or coverage of medically necessary treatment of mental, emotional, nervous, or substance use disorders or conditions or limit coverage only to alleviation of the insured's current symptoms.

(3) All utilization review conducted by the insurer concerning diagnosis, prevention, and treatment of insureds diagnosed with mental, emotional, nervous, or substance use disorders or conditions shall be conducted in accordance with the requirements of subsections (k) through (w).

(4) An insurer that authorizes a specific type of treatment by a provider pursuant to this Section shall not rescind or modify the authorization after that provider renders the health care service in good faith and pursuant to this authorization for any reason, including, but not limited to, the insurer's subsequent cancellation or modification of the insured's or policyholder's contract, or the insured's or policyholder's eligibility. Nothing in this Section shall require the insurer to cover a treatment when the authorization was granted based on a material misrepresentation by the insured, the policyholder, or the provider. Nothing in this Section shall require Medicaid managed care organizations to pay for services if the

individual was not eligible for Medicaid at the time the service was rendered. Nothing in this Section shall require an insurer to pay for services if the individual was not the insurer's enrollee at the time services were rendered. As used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results in or could result in a substantial change in the situation.

(j) An insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance, and shall not include or enforce a contract term that excludes otherwise covered benefits on the basis that those services should be or could be covered by a public entitlement program. Nothing in this subsection shall be construed to require an insurer to cover benefits that have been authorized and provided for a covered person by a public entitlement program. Medicaid managed care organizations are not subject to this subsection.

(k) An insurer shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and

treatment of mental, emotional, nervous, or substance use disorders or conditions on current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care. All denials and appeals shall be reviewed by a professional with experience or expertise comparable to the provider requesting the authorization.

(l) In conducting utilization review of all covered health care services for the diagnosis, prevention, and treatment of mental, emotional, and nervous disorders or conditions, an insurer shall apply the criteria and guidelines set forth in the most recent version of the treatment criteria developed by an unaffiliated nonprofit professional association for the relevant clinical specialty or, for Medicaid managed care organizations, criteria and guidelines determined by the Department of Healthcare and Family Services that are consistent with generally accepted standards of mental, emotional, nervous or substance use disorder or condition care. Pursuant to subsection (b), in conducting utilization review of all covered services and benefits for the diagnosis, prevention, and treatment of substance use disorders an insurer shall use the most recent edition of the patient placement criteria established by the American Society of Addiction Medicine.

(m) In conducting utilization review relating to level of care placement, continued stay, transfer, discharge, or any other patient care decisions that are within the scope of the

sources specified in subsection (l), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the assessment of the insured using the relevant patient placement criteria as specified in subsection (l). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its assessment using the relevant criteria as specified in subsection (l) to the provider of the service and the patient.

If an insurer purchases or licenses utilization review criteria pursuant to this subsection, the insurer shall verify and document before use that the criteria were developed in accordance with subsection (k).

(n) In conducting utilization review that is outside the scope of the criteria as specified in subsection (l) or relates to the advancements in technology or in the types or levels of care that are not addressed in the most recent versions of the sources specified in subsection (l), an insurer shall conduct utilization review in accordance with subsection (k).

(o) This Section does not in any way limit the rights of a patient under the Medical Patient Rights Act.

(p) This Section does not in any way limit early and

periodic screening, diagnostic, and treatment benefits as defined under 42 U.S.C. 1396d(r).

(q) To ensure the proper use of the criteria described in subsection (l), every insurer shall do all of the following:

(1) Educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the utilization review criteria.

(2) Make the educational program available to other stakeholders, including the insurer's participating or contracted providers and potential participants, beneficiaries, or covered lives. The education program must be provided at least once a year, in-person or digitally, or recordings of the education program must be made available to the aforementioned stakeholders.

(3) Provide, at no cost, the utilization review criteria and any training material or resources to providers and insured patients upon request. For utilization review criteria not concerning level of care placement, continued stay, transfer, discharge, or other patient care decisions used by the insurer pursuant to subsection (m), the insurer may place the criteria on a secure, password-protected website so long as the access requirements of the website do not unreasonably restrict access to insureds or their providers. No restrictions shall be placed upon the insured's or treating provider's

access right to utilization review criteria obtained under this paragraph at any point in time, including before an initial request for authorization.

(4) Track, identify, and analyze how the utilization review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decision making that covers how medical necessity decisions are made; this assessment shall cover all aspects of utilization review as defined in subsection (h).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization review process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(8) Maintain documentation of interrater reliability testing and the remediation actions taken for those with pass rates lower than 90% and submit to the Department of Insurance or, in the case of Medicaid managed care organizations, the Department of Healthcare and Family

Services the testing results and a summary of remedial actions as part of parity compliance reporting set forth in subsection (k) of Section 370c.1.

(r) This Section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions covered by an insurance policy, including prescription drugs.

(s) This Section applies to an insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and conducts utilization review as defined in this Section, including Medicaid managed care organizations, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(t) If the Director determines that an insurer has violated this Section, the Director may, after appropriate notice and opportunity for hearing, by order, assess a civil penalty between $1,000 and $5,000 for each violation. Moneys collected from penalties shall be deposited into the Parity Advancement Fund established in subsection (i) of Section 370c.1.

(u) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in

operation, that undermine, alter, or conflict with the requirements of this Section.

(v) The provisions of this Section are severable. If any provision of this Section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(w) Beginning January 1, 2026, coverage for medically necessary treatment of mental, emotional, or nervous disorders or conditions shall comply with the following requirements:

(1) No policy shall require prior authorization for outpatient or partial hospitalization services for treatment of mental, emotional, or nervous disorders or conditions provided by a physician licensed to practice medicine in all branches, a licensed clinical psychologist, a licensed clinical social worker, a licensed clinical professional counselor, a licensed marriage and family therapist, a licensed speech-language pathologist, or any other type of licensed, certified, or legally authorized provider, including trainees working under the supervision of a licensed health care professional listed under this subsection, or facility whose outpatient or partial hospitalization services the policy covers for treatment of mental, emotional, or nervous disorders or conditions. Such coverage may be subject to concurrent and retrospective review consistent

with the utilization review provisions in subsections (h) through (n) and Section 370c.1. Nothing in this paragraph (1) supersedes a health maintenance organization's referral requirement for services from nonparticipating providers. An insurer may require providers or facilities to notify the insurer of the initiation of treatment as specified in this subsection, except to the extent prohibited by Section 370c.1 with respect to treatment limitations in a benefit classification or subclassification. No such coverage shall be subject to concurrent review for any services furnished before an applicable notification deadline, subject to the following:

(A) In the case of outpatient treatment, for an insurer that is not a Medicaid managed care organization, the insurer may set a notification deadline of 2 business days after the initiation of the covered person's treatment. A Medicaid managed care organization may set a deadline of 24 hours after the initiation of treatment. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol within the 24-hour period following initiation, the treatment provider or facility shall have one additional business day to provide the notification to the Medicaid managed care

organization.

(B) In the case of a partial hospitalization program, for an insurer that is not a Medicaid managed care organization, the insurer may set a notification deadline of 48 hours after the initiation of the covered person's treatment. A Medicaid managed care organization may set a deadline of 24 hours after the initiation of treatment. If the Medicaid managed care organization is not capable of accepting the notification in accordance with the contractual protocol during the 24-hour period following initiation, the treatment provider or facility shall have one additional business day to provide the notification to the Medicaid managed care organization.

(2) No policy shall require prior authorization for inpatient treatment at a hospital for mental, emotional, or nervous disorders or conditions at a participating provider. Additionally, no such coverage shall be subject to concurrent review for the first 72 hours after admission, provided that the provider must notify the insurer of both the admission and the initial treatment plan within 48 hours of admission. A discharge plan must be fully developed and continuity services prepared to meet the patient's needs and the patient's community preference upon release. Recommended level of care

placements identified in the discharge plan shall comply with generally accepted standards of care, as defined in subsection (h).

(A) If the provider satisfies the conditions of paragraph (2), then the insurer shall approve coverage of the recommended level of care, if applicable, upon discharge subject to concurrent review.

(B) Nothing in this paragraph supersedes a health maintenance organization's referral requirement for services from nonparticipating providers upon a patient's discharge from a hospital or facility.

(C) Concurrent review for such coverage must be consistent with the utilization review provisions in subsections (h) through (n).

(D) In this subsection, residential treatment that is not otherwise identified in the discharge plan is not inpatient hospitalization.

(3) Treatment provided under this subsection may be reviewed retrospectively. If coverage is denied retrospectively, neither the insurer nor the participating provider shall bill, and the insured shall not be liable, for any treatment under this subsection through the date the adverse determination is issued, other than any copayment, coinsurance, or deductible for the stay through that date as applicable under the policy. Coverage shall not be retrospectively denied for the first 72 hours of

admission to inpatient hospitalization for treatment of mental, emotional, or nervous disorders or conditions, or before the applicable deadline under paragraph (1) of this subsection for outpatient treatment or partial hospitalization programs, at a participating provider except:

(A) upon reasonable determination that the inpatient mental health treatment was not provided;

(B) upon determination that the patient receiving the treatment was not an insured, enrollee, or beneficiary under the policy;

(C) upon material misrepresentation by the patient or health care provider. In this item (C), "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation;

(D) upon determination that a service was excluded under the terms of coverage. In that case, the limitation to billing for a copayment, coinsurance, or deductible shall not apply;

(E) for outpatient treatment or partial hospitalization programs only, upon determination that a service was not medically necessary consistent with subsections (h) through (n); or

(F) upon determination that the patient did not consent to the treatment and that there was no court

order mandating the treatment.

Nothing in this subsection shall be construed to require a policy to cover any health care service excluded under the terms of coverage.

This subsection does not apply to coverage for any prescription or over-the-counter drug.

Nothing in this subsection shall be construed to require the medical assistance program to reimburse for services not covered by the medical assistance program as authorized by the Illinois Public Aid Code or the Children's Health Insurance Program Act.

(x) Notwithstanding any provision of this Section, nothing shall require the medical assistance program under Article V of the Illinois Public Aid Code or the Children's Health Insurance Program Act to violate any applicable federal laws, regulations, or grant requirements, including requirements for utilization management, or any State or federal consent decrees. Nothing in subsection (g) or (w) shall prevent the Department of Healthcare and Family Services from requiring a health care provider to use specified level of care, admission, continued stay, or discharge criteria, including, but not limited to, those under Section 5-5.23 of the Illinois Public Aid Code, as long as the Department of Healthcare and Family Services, subject to applicable federal laws, regulations, or grant requirements, including requirements for utilization management, does not require a health care

provider to seek prior authorization or concurrent review from the Department of Healthcare and Family Services, a Medicaid managed care organization, or a utilization review organization under the circumstances expressly prohibited by subsections (g) and (w). Nothing in this Section prohibits a health plan, including a Medicaid managed care organization, from conducting reviews for medical necessity, clinical appropriateness, safety, fraud, waste, or abuse and reporting suspected fraud, waste, or abuse according to State and federal requirements. Nothing in this Section limits the authority of the Department of Healthcare and Family Services or another State agency, or a Medicaid managed care organization on the State agency's behalf, to (i) implement or require programs, services, screenings, assessments, tools, or reviews to comply with applicable federal law, federal regulation, federal grant requirements, any State or federal consent decrees or court orders, or any applicable case law, such as Olmstead v. L.C., 527 U.S. 581 (1999), or (ii) administer or require programs, services, screenings, assessments, tools, or reviews established under State or federal laws, rules, or regulations in compliance with State or federal laws, rules, or regulations, including, but not limited to, the Children's Mental Health Act and the Mental Health and Developmental Disabilities Administrative Act.

(y) (Blank).

(z) Notwithstanding any other provision of this Code, a

health insurance issuer subject to regulation under this Code shall comply with standardized reimbursement rates and payment methodologies established by the Illinois Health Care Cost and Payment Board under the Illinois All-Payer Health Care Payment and Global Budget Act. Any contract provision inconsistent with such standardized rates is void as against public policy. (Source: P.A. 103-426, eff. 8-4-23; 103-650, eff. 1-1-25; 103-1040, eff. 8-9-24; 104-28, eff. 1-1-26; 104-417, eff. 8-15-25.)

Section 87. The Health Maintenance Organization Act is amended by changing Section 4-2 as follows:

(215 ILCS 125/4-2) (from Ch. 111 1/2, par. 1408.2)

Sec. 4-2. Medical assistance; coverage of child.

(a) In this Section, "Medicaid" means medical assistance authorized under Section 1902 of the Social Security Act.

(b) A contract or evidence of coverage delivered, issued for delivery, renewed, or amended by a Health Maintenance Organization may not contain any provision which limits or excludes payments of health care services to or on behalf of the enrollee because the enrollee or any covered dependent is eligible for or is receiving Medicaid benefits in this or any other state.

(c) To the extent that payment for covered expenses has been made under Article V, VI, or VII of the Illinois Public

Aid Code for health care services provided to an individual, if a third party has a legal liability to make payments for those health care services, the State is considered to have acquired the rights of the individual to payment.

(d) If a child is covered under a health care plan of a Health Maintenance Organization in which the child's noncustodial parent is an enrollee, the Health Maintenance Organization shall:

(1) Provide necessary information to the child's custodial parent to enable the child to obtain benefits under that health care plan.

(2) Permit the child's custodial parent (or the provider, with the custodial parent's approval) to submit claims for payment for covered services without the approval of the noncustodial parent.

(3) Make payments on claims submitted in accordance with paragraph (2) directly to the custodial parent, the provider of health care services, or the state Medicaid agency.

(e) A Health Maintenance Organization may not deny enrollment of a child under the health care plan in which the child's parent is an enrollee on any of the following grounds:

(1) The child was born out of wedlock.

(2) The child is not claimed as a dependent on the parent's federal income tax return.

(3) The child does not reside with the parent or in the

service area covered by the health care plan.

(f) If a parent is required by a court or administrative order to provide coverage for a child under a health care plan in which the parent is enrolled, and that offers coverage for eligible dependents, the Health Maintenance Organization, upon receiving a copy of the order, shall:

(1) Upon application, permit the parent to enroll in the health care plan a child who is otherwise eligible for that coverage, without regard to any enrollment season restrictions that might otherwise be applicable as to the time period within which a person may enroll in the plan.

(2) Enroll the child in the health care plan upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering a program for enforcing child support and establishing paternity under 42 U.S.C. 651 through 669 (or another child support enforcement program), if the parent is enrolled in the health care plan but fails to apply for enrollment of the child.

(g) A Health Maintenance Organization may not impose, on a state agency that has been assigned the rights of an enrollee in a health care plan who receives Medicaid benefits, requirements that are different from requirements applicable to an assignee of any other enrollee in that health care plan.

(h) Nothing in subsections (e) and (f) prevents a Health Maintenance Organization from denying any such application if

the child is not eligible for coverage according to the Health Maintenance Organization's medical underwriting standards.

(i) The Health Maintenance Organization may not disenroll (or otherwise eliminate coverage of) the child from the health care plan unless the Health Maintenance Organization is provided satisfactory written evidence of either of the following:

(1) The court or administrative order is no longer in effect.

(2) The child is or will be enrolled in a comparable health care plan obtained by the parent under such order and that enrollment is currently in effect or will take effect not later than the date the prior coverage is terminated.

(j) A Health Maintenance Organization shall reimburse hospitals in accordance with standardized reimbursement rates and methodologies established by the Illinois Health Care Cost and Payment Board pursuant to the Illinois All-Payer Health Care Payment and Global Budget Act.

(Source: P.A. 89-183, eff. 1-1-96.)

Section 89. The Illinois Public Aid Code is amended by changing Section 5-5 as follows:

(305 ILCS 5/5-5)

Sec. 5-5. Medical services. The Illinois Department, by

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

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

Notwithstanding any other provision of this Section, a comprehensive tobacco use cessation program that includes purchasing prescription drugs or prescription medical devices

approved by the Food and Drug Administration shall be covered under the medical assistance program under this Article for persons who are otherwise eligible for assistance under this Article.

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

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

95.507. The Department shall submit the memorandum of understanding or interagency agreement, the cost allocation plan, and all other necessary documentation to the Centers for Medicare and Medicaid Services for review and approval. Coverage under this paragraph shall be contingent upon federal approval.

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

Upon receipt of federal approval of an amendment to the Illinois Title XIX State Plan for this purpose, the Department shall authorize the Chicago Public Schools (CPS) to procure a vendor or vendors to manufacture eyeglasses for individuals enrolled in a school within the CPS system. CPS shall ensure that its vendor or vendors are enrolled as providers in the medical assistance program and in any capitated Medicaid managed care entity (MCE) serving individuals enrolled in a school within the CPS system. Under any contract procured under this provision, the vendor or vendors must serve only individuals enrolled in a school within the CPS system. Claims for services provided by CPS's vendor or vendors to recipients of benefits in the medical assistance program under this Code,

the Children's Health Insurance Program, or the Covering ALL KIDS Health Insurance Program shall be submitted to the Department or the MCE in which the individual is enrolled for payment and shall be reimbursed at the Department's or the MCE's established rates or rate methodologies for eyeglasses.

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

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

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

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

profession.

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

Subject to federal approval, 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. The rates paid for nitrous oxide sedation shall not be impacted by this paragraph and shall remain the same as the rates in effect on December 31, 2024.

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

Center or other enrolled provider, as determined by the Department, through which dental services covered under this Section are performed. The Department shall establish a process for payment of claims for reimbursement for covered dental services rendered under this provision.

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

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

construed to limit or preempt a home rule unit's or school district's authority to establish, change, or administer a school-based dental program in addition to, or independent of, the school-based dental program administered by the Department.

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

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

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

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

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

(C) A mammogram at the age and intervals considered

medically necessary by the individual's health care provider for individuals under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.

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

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

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

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

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

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

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

For purposes of this Section:

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

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

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

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

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

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

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

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

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

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

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

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

Subject to federal approval, the Department shall establish a rate methodology for mammography at federally qualified health centers and other encounter-rate clinics. These clinics or centers may also collaborate with other

hospital-based mammography facilities. By January 1, 2016, the Department shall report to the General Assembly on the status of the provision set forth in this paragraph.

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

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

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

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

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

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

On or after July 1, 2022, individuals who are otherwise

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

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

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

The Illinois Department, in cooperation with the

Departments of Human Services (as successor to the Department of Alcoholism and Substance Abuse) and Public Health, through a public awareness campaign, may provide information concerning treatment for alcoholism and drug abuse and addiction, prenatal health care, and other pertinent programs directed at reducing the number of drug-affected infants born to recipients of medical assistance.

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

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

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

rule, shall develop qualifications for sponsors of Partnerships. Nothing in this Section shall be construed to require that the sponsor organization be a medical organization.

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

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

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

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

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

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

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

The Illinois Department shall require health care providers to maintain records that document the medical care and services provided to recipients of Medical Assistance under this Article. Such records must be retained for a period of not less than 6 years from the date of service or as

provided by applicable State law, whichever period is longer, except that if an audit is initiated within the required retention period then the records must be retained until the audit is completed and every exception is resolved. The Illinois Department shall require health care providers to make available, when authorized by the patient, in writing, the medical records in a timely fashion to other health care providers who are treating or serving persons eligible for Medical Assistance under this Article. All dispensers of medical services shall be required to maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, details and receipt of the health care provided to persons eligible for medical assistance under this Code, in accordance with regulations promulgated by the Illinois Department. The rules and regulations shall require that proof of the receipt of prescription drugs, dentures, prosthetic devices and eyeglasses by eligible persons under this Section accompany each claim for reimbursement submitted by the dispenser of such medical services. No such claims for reimbursement shall be approved for payment by the Illinois Department without such proof of receipt, unless the Illinois Department shall have put into effect and shall be operating a system of post-payment audit and review which shall, on a sampling basis, be deemed adequate by the Illinois Department to assure that such drugs, dentures, prosthetic devices and eyeglasses

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

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

Notwithstanding any other law to the contrary, the Illinois Department shall, within 365 days after August 15, 2014 (the effective date of Public Act 98-963), establish procedures to permit ID/DD facilities licensed under the ID/DD Community Care Act and MC/DD facilities licensed under the

MC/DD Act to submit monthly billing claims for reimbursement purposes. Following development of these procedures, the Department shall have an additional 365 days to test the viability of the new system and to ensure that any necessary operational or structural changes to its information technology platforms are implemented.

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

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

Enrollment of a vendor shall be subject to a provisional period and shall be conditional for one year. During the period of conditional enrollment, the Department may terminate

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

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

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

The Department shall define or specify the following: (i) by provider notice, the "category of risk of the vendor" for each type of vendor, which shall take into account the level of screening applicable to a particular category of vendor under federal law and regulations; (ii) by rule or provider notice,

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

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

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

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

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

(4) In the case of a provider operated by a unit of local government with a population exceeding 3,000,000

when local government funds finance federal participation for claims payments.

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

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

Claims that are not submitted and received in compliance with the foregoing requirements shall not be eligible for

payment under the medical assistance program, and the State shall have no liability for payment of those claims.

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

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

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

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

The Illinois Department shall establish policies, procedures, standards and criteria by rule for the acquisition, repair and replacement of orthotic and prosthetic devices and durable medical equipment. Such rules shall provide, but not be limited to, the following services: (1)

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

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

In order to promote environmental responsibility, meet the needs of recipients and enrollees, and achieve significant

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

organizations.

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

agency representatives and stakeholders representing the institutional and home and community-based long term care interests. This Section shall not restrict the Department from implementing lower level of care eligibility criteria for community-based services in circumstances where federal approval has been granted.

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

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

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

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

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

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

The period covered by each report shall be the 3 years ending on the June 30 prior to the report. The report shall

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

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

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

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

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

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

On or after July 1, 2015, opioid antagonists prescribed for the treatment of an opioid overdose, including the medication product, administration devices, and any pharmacy fees or hospital fees related to the dispensing, distribution, and administration of the opioid antagonist, shall be covered

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

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

A federally qualified health center, as defined in Section 1905(l)(2)(B) of the federal Social Security Act, shall be reimbursed by the Department in accordance with the federally qualified health center's encounter rate for services provided

to medical assistance recipients that are performed by a dental hygienist, as defined under the Illinois Dental Practice Act, working under the general supervision of a dentist and employed by a federally qualified health center.

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

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

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

Palliative Care Act.

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

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

implementation of the newborn screening test fees by the Department of Public Health.

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

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

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

Subject to federal approval, the Department of Healthcare and Family Services shall align Medicaid hospital reimbursement with standardized rates and global hospital budgets established by the Illinois Health Care Cost and

Payment Board under the Illinois All-Payer Health Care Payment and Global Budget Act.

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

Section 97. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

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