



Rep. Sara Feigenholtz

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1 AMENDMENT TO SENATE BILL 2840

2 AMENDMENT NO. _____. Amend Senate Bill 2840 by replacing
3 everything after the enacting clause with the following:

4 "Section 1. Short title. This Act may be referred to as the
5 Save Medicaid Access and Resources Together (SMART) Act.

6 Section 5. Purpose. In order to address the significant
7 spending and liability deficit in the medical assistance
8 program budget of the Department of Healthcare and Family
9 Services, the SMART Act hereby implements changes,
10 improvements, and efficiencies to enhance Medicaid program
11 integrity to prevent client and provider fraud; imposes
12 controls on use of Medicaid services to prevent over-use or
13 waste; expands cost-sharing by clients; redesigns the Medicaid
14 healthcare delivery system; and makes rate adjustments and
15 reductions to update rates or reflect budget realities.

1 Section 10. The Illinois Administrative Procedure Act is
2 amended by changing Section 5-45 as follows:

3 (5 ILCS 100/5-45) (from Ch. 127, par. 1005-45)

4 Sec. 5-45. Emergency rulemaking.

5 (a) "Emergency" means the existence of any situation that
6 any agency finds reasonably constitutes a threat to the public
7 interest, safety, or welfare.

8 (b) If any agency finds that an emergency exists that
9 requires adoption of a rule upon fewer days than is required by
10 Section 5-40 and states in writing its reasons for that
11 finding, the agency may adopt an emergency rule without prior
12 notice or hearing upon filing a notice of emergency rulemaking
13 with the Secretary of State under Section 5-70. The notice
14 shall include the text of the emergency rule and shall be
15 published in the Illinois Register. Consent orders or other
16 court orders adopting settlements negotiated by an agency may
17 be adopted under this Section. Subject to applicable
18 constitutional or statutory provisions, an emergency rule
19 becomes effective immediately upon filing under Section 5-65 or
20 at a stated date less than 10 days thereafter. The agency's
21 finding and a statement of the specific reasons for the finding
22 shall be filed with the rule. The agency shall take reasonable
23 and appropriate measures to make emergency rules known to the
24 persons who may be affected by them.

25 (c) An emergency rule may be effective for a period of not

1 longer than 150 days, but the agency's authority to adopt an
2 identical rule under Section 5-40 is not precluded. No
3 emergency rule may be adopted more than once in any 24 month
4 period, except that this limitation on the number of emergency
5 rules that may be adopted in a 24 month period does not apply
6 to (i) emergency rules that make additions to and deletions
7 from the Drug Manual under Section 5-5.16 of the Illinois
8 Public Aid Code or the generic drug formulary under Section
9 3.14 of the Illinois Food, Drug and Cosmetic Act, (ii)
10 emergency rules adopted by the Pollution Control Board before
11 July 1, 1997 to implement portions of the Livestock Management
12 Facilities Act, (iii) emergency rules adopted by the Illinois
13 Department of Public Health under subsections (a) through (i)
14 of Section 2 of the Department of Public Health Act when
15 necessary to protect the public's health, (iv) emergency rules
16 adopted pursuant to subsection (n) of this Section, or (v)
17 emergency rules adopted pursuant to subsection (o) of this
18 Section. Two or more emergency rules having substantially the
19 same purpose and effect shall be deemed to be a single rule for
20 purposes of this Section.

21 (d) In order to provide for the expeditious and timely
22 implementation of the State's fiscal year 1999 budget,
23 emergency rules to implement any provision of Public Act 90-587
24 or 90-588 or any other budget initiative for fiscal year 1999
25 may be adopted in accordance with this Section by the agency
26 charged with administering that provision or initiative,

1 except that the 24-month limitation on the adoption of
2 emergency rules and the provisions of Sections 5-115 and 5-125
3 do not apply to rules adopted under this subsection (d). The
4 adoption of emergency rules authorized by this subsection (d)
5 shall be deemed to be necessary for the public interest,
6 safety, and welfare.

7 (e) In order to provide for the expeditious and timely
8 implementation of the State's fiscal year 2000 budget,
9 emergency rules to implement any provision of this amendatory
10 Act of the 91st General Assembly or any other budget initiative
11 for fiscal year 2000 may be adopted in accordance with this
12 Section by the agency charged with administering that provision
13 or initiative, except that the 24-month limitation on the
14 adoption of emergency rules and the provisions of Sections
15 5-115 and 5-125 do not apply to rules adopted under this
16 subsection (e). The adoption of emergency rules authorized by
17 this subsection (e) shall be deemed to be necessary for the
18 public interest, safety, and welfare.

19 (f) In order to provide for the expeditious and timely
20 implementation of the State's fiscal year 2001 budget,
21 emergency rules to implement any provision of this amendatory
22 Act of the 91st General Assembly or any other budget initiative
23 for fiscal year 2001 may be adopted in accordance with this
24 Section by the agency charged with administering that provision
25 or initiative, except that the 24-month limitation on the
26 adoption of emergency rules and the provisions of Sections

1 5-115 and 5-125 do not apply to rules adopted under this
2 subsection (f). The adoption of emergency rules authorized by
3 this subsection (f) shall be deemed to be necessary for the
4 public interest, safety, and welfare.

5 (g) In order to provide for the expeditious and timely
6 implementation of the State's fiscal year 2002 budget,
7 emergency rules to implement any provision of this amendatory
8 Act of the 92nd General Assembly or any other budget initiative
9 for fiscal year 2002 may be adopted in accordance with this
10 Section by the agency charged with administering that provision
11 or initiative, except that the 24-month limitation on the
12 adoption of emergency rules and the provisions of Sections
13 5-115 and 5-125 do not apply to rules adopted under this
14 subsection (g). The adoption of emergency rules authorized by
15 this subsection (g) shall be deemed to be necessary for the
16 public interest, safety, and welfare.

17 (h) In order to provide for the expeditious and timely
18 implementation of the State's fiscal year 2003 budget,
19 emergency rules to implement any provision of this amendatory
20 Act of the 92nd General Assembly or any other budget initiative
21 for fiscal year 2003 may be adopted in accordance with this
22 Section by the agency charged with administering that provision
23 or initiative, except that the 24-month limitation on the
24 adoption of emergency rules and the provisions of Sections
25 5-115 and 5-125 do not apply to rules adopted under this
26 subsection (h). The adoption of emergency rules authorized by

1 this subsection (h) shall be deemed to be necessary for the
2 public interest, safety, and welfare.

3 (i) In order to provide for the expeditious and timely
4 implementation of the State's fiscal year 2004 budget,
5 emergency rules to implement any provision of this amendatory
6 Act of the 93rd General Assembly or any other budget initiative
7 for fiscal year 2004 may be adopted in accordance with this
8 Section by the agency charged with administering that provision
9 or initiative, except that the 24-month limitation on the
10 adoption of emergency rules and the provisions of Sections
11 5-115 and 5-125 do not apply to rules adopted under this
12 subsection (i). The adoption of emergency rules authorized by
13 this subsection (i) shall be deemed to be necessary for the
14 public interest, safety, and welfare.

15 (j) In order to provide for the expeditious and timely
16 implementation of the provisions of the State's fiscal year
17 2005 budget as provided under the Fiscal Year 2005 Budget
18 Implementation (Human Services) Act, emergency rules to
19 implement any provision of the Fiscal Year 2005 Budget
20 Implementation (Human Services) Act may be adopted in
21 accordance with this Section by the agency charged with
22 administering that provision, except that the 24-month
23 limitation on the adoption of emergency rules and the
24 provisions of Sections 5-115 and 5-125 do not apply to rules
25 adopted under this subsection (j). The Department of Public Aid
26 may also adopt rules under this subsection (j) necessary to

1 administer the Illinois Public Aid Code and the Children's
2 Health Insurance Program Act. The adoption of emergency rules
3 authorized by this subsection (j) shall be deemed to be
4 necessary for the public interest, safety, and welfare.

5 (k) In order to provide for the expeditious and timely
6 implementation of the provisions of the State's fiscal year
7 2006 budget, emergency rules to implement any provision of this
8 amendatory Act of the 94th General Assembly or any other budget
9 initiative for fiscal year 2006 may be adopted in accordance
10 with this Section by the agency charged with administering that
11 provision or initiative, except that the 24-month limitation on
12 the adoption of emergency rules and the provisions of Sections
13 5-115 and 5-125 do not apply to rules adopted under this
14 subsection (k). The Department of Healthcare and Family
15 Services may also adopt rules under this subsection (k)
16 necessary to administer the Illinois Public Aid Code, the
17 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
18 ~~Pharmaceutical Assistance~~ Act, the Senior Citizens and
19 Disabled Persons Prescription Drug Discount Program Act (now
20 the Illinois Prescription Drug Discount Program Act), and the
21 Children's Health Insurance Program Act. The adoption of
22 emergency rules authorized by this subsection (k) shall be
23 deemed to be necessary for the public interest, safety, and
24 welfare.

25 (l) In order to provide for the expeditious and timely
26 implementation of the provisions of the State's fiscal year

1 2007 budget, the Department of Healthcare and Family Services
2 may adopt emergency rules during fiscal year 2007, including
3 rules effective July 1, 2007, in accordance with this
4 subsection to the extent necessary to administer the
5 Department's responsibilities with respect to amendments to
6 the State plans and Illinois waivers approved by the federal
7 Centers for Medicare and Medicaid Services necessitated by the
8 requirements of Title XIX and Title XXI of the federal Social
9 Security Act. The adoption of emergency rules authorized by
10 this subsection (l) shall be deemed to be necessary for the
11 public interest, safety, and welfare.

12 (m) In order to provide for the expeditious and timely
13 implementation of the provisions of the State's fiscal year
14 2008 budget, the Department of Healthcare and Family Services
15 may adopt emergency rules during fiscal year 2008, including
16 rules effective July 1, 2008, in accordance with this
17 subsection to the extent necessary to administer the
18 Department's responsibilities with respect to amendments to
19 the State plans and Illinois waivers approved by the federal
20 Centers for Medicare and Medicaid Services necessitated by the
21 requirements of Title XIX and Title XXI of the federal Social
22 Security Act. The adoption of emergency rules authorized by
23 this subsection (m) shall be deemed to be necessary for the
24 public interest, safety, and welfare.

25 (n) In order to provide for the expeditious and timely
26 implementation of the provisions of the State's fiscal year

1 2010 budget, emergency rules to implement any provision of this
2 amendatory Act of the 96th General Assembly or any other budget
3 initiative authorized by the 96th General Assembly for fiscal
4 year 2010 may be adopted in accordance with this Section by the
5 agency charged with administering that provision or
6 initiative. The adoption of emergency rules authorized by this
7 subsection (n) shall be deemed to be necessary for the public
8 interest, safety, and welfare. The rulemaking authority
9 granted in this subsection (n) shall apply only to rules
10 promulgated during Fiscal Year 2010.

11 (o) In order to provide for the expeditious and timely
12 implementation of the provisions of the State's fiscal year
13 2011 budget, emergency rules to implement any provision of this
14 amendatory Act of the 96th General Assembly or any other budget
15 initiative authorized by the 96th General Assembly for fiscal
16 year 2011 may be adopted in accordance with this Section by the
17 agency charged with administering that provision or
18 initiative. The adoption of emergency rules authorized by this
19 subsection (o) is deemed to be necessary for the public
20 interest, safety, and welfare. The rulemaking authority
21 granted in this subsection (o) applies only to rules
22 promulgated on or after the effective date of this amendatory
23 Act of the 96th General Assembly through June 30, 2011.

24 (p) In order to provide for the expeditious and timely
25 implementation of the provisions of this amendatory Act of the
26 97th General Assembly, emergency rules to implement any

1 provision of this amendatory Act of the 97th General Assembly
2 may be adopted in accordance with this subsection (p) by the
3 agency charged with administering that provision or
4 initiative. The 150-day limitation of the effective period of
5 emergency rules does not apply to rules adopted under this
6 subsection (p), and the effective period may continue through
7 June 30, 2013. The 24-month limitation on the adoption of
8 emergency rules does not apply to rules adopted under this
9 subsection (p). The adoption of emergency rules authorized by
10 this subsection (p) is deemed to be necessary for the public
11 interest, safety, and welfare.

12 (Source: P.A. 95-12, eff. 7-2-07; 95-331, eff. 8-21-07; 96-45,
13 eff. 7-15-09; 96-958, eff. 7-1-10; 96-1500, eff. 1-18-11.)

14 Section 11. The Civil Administrative Code of Illinois is
15 amended by changing Section 5-235 as follows:

16 (20 ILCS 5/5-235) (was 20 ILCS 5/7.03)

17 Sec. 5-235. In the Department of Public Health.

18 (a) The Director of Public Health shall be either a
19 physician licensed to practice medicine in all of its branches
20 in Illinois or a person who has administrative experience in
21 public health work at the local, state, or national level in
22 accordance with subsection (b).

23 If the Director is not a physician licensed to practice
24 medicine in all its branches, then a Medical Director ~~The~~

1 ~~Assistant Director of Public Health~~ shall be appointed who
2 shall be a physician licensed to practice medicine in all its
3 branches ~~a person who has administrative experience in public~~
4 ~~health work.~~ The Medical Director shall report directly to the
5 Director. If the Director is not a physician, the Medical
6 Director shall have primary responsibility for overseeing the
7 following regulatory and policy areas:

8 (1) Department responsibilities concerning hospital
9 and health care facility regulation, emergency services,
10 ambulatory surgical treatment centers, health care
11 professional regulation and credentialing, advising the
12 Board of Health, patient safety initiatives, and the
13 State's response to disease prevention and outbreak
14 management and control.

15 (2) Any other duties assigned by the Director or
16 required by law.

17 (b) A Director of Public Health who is not a physician
18 licensed to practice medicine in all its branches shall at a
19 minimum have the following education and experience:

20 (1) 5 years of full-time administrative experience in
21 public health and a master's degree in public health from
22 (i) a college or university accredited by the North Central
23 Association or (ii) any other nationally recognized
24 regional accrediting agency; or

25 (2) 5 years of full-time administrative experience in
26 public health and a graduate degree in a related field from

1 (i) a college or university accredited by the North Central
2 Association or (ii) any other nationally recognized
3 regional accrediting agency. (For the purposes of this item
4 (2), "a graduate degree in a related field" includes, but
5 is not limited to, a master's degree in public
6 administration, nursing, environmental health, community
7 health, or health education.

8 (c) The Assistant Director of Public Health shall be a
9 person who has administrative experience in public health work.

10 (Source: P.A. 91-239, eff. 1-1-00.)

11 Section 12. The Personnel Code is amended by changing
12 Section 4d as follows:

13 (20 ILCS 415/4d) (from Ch. 127, par. 63b104d)

14 Sec. 4d. Partial exemptions. The following positions in
15 State service are exempt from jurisdictions A, B, and C to the
16 extent stated for each, unless those jurisdictions are extended
17 as provided in this Act:

18 (1) In each department, board or commission that now
19 maintains or may hereafter maintain a major administrative
20 division, service or office in both Sangamon County and
21 Cook County, 2 private secretaries for the director or
22 chairman thereof, one located in the Cook County office and
23 the other located in the Sangamon County office, shall be
24 exempt from jurisdiction B; in all other departments,

1 boards and commissions one private secretary for the
2 director or chairman thereof shall be exempt from
3 jurisdiction B. In all departments, boards and commissions
4 one confidential assistant for the director or chairman
5 thereof shall be exempt from jurisdiction B. This paragraph
6 is subject to such modifications or waiver of the
7 exemptions as may be necessary to assure the continuity of
8 federal contributions in those agencies supported in whole
9 or in part by federal funds.

10 (2) The resident administrative head of each State
11 charitable, penal and correctional institution, the
12 chaplains thereof, and all member, patient and inmate
13 employees are exempt from jurisdiction B.

14 (3) The Civil Service Commission, upon written
15 recommendation of the Director of Central Management
16 Services, shall exempt from jurisdiction B other positions
17 which, in the judgment of the Commission, involve either
18 principal administrative responsibility for the
19 determination of policy or principal administrative
20 responsibility for the way in which policies are carried
21 out, except positions in agencies which receive federal
22 funds if such exemption is inconsistent with federal
23 requirements, and except positions in agencies supported
24 in whole by federal funds.

25 (4) All beauticians and teachers of beauty culture and
26 teachers of barbering, and all positions heretofore paid

1 under Section 1.22 of "An Act to standardize position
2 titles and salary rates", approved June 30, 1943, as
3 amended, shall be exempt from jurisdiction B.

4 (5) Licensed attorneys in positions as legal or
5 technical advisors, positions in the Department of Natural
6 Resources requiring incumbents to be either a registered
7 professional engineer or to hold a bachelor's degree in
8 engineering from a recognized college or university,
9 licensed physicians in positions of medical administrator
10 or physician or physician specialist (including
11 psychiatrists), and registered nurses (except those
12 registered nurses employed by the Department of Public
13 Health), except those in positions in agencies which
14 receive federal funds if such exemption is inconsistent
15 with federal requirements and except those in positions in
16 agencies supported in whole by federal funds, are exempt
17 from jurisdiction B only to the extent that the
18 requirements of Section 8b.1, 8b.3 and 8b.5 of this Code
19 need not be met.

20 (6) All positions established outside the geographical
21 limits of the State of Illinois to which appointments of
22 other than Illinois citizens may be made are exempt from
23 jurisdiction B.

24 (7) Staff attorneys reporting directly to individual
25 Commissioners of the Illinois Workers' Compensation
26 Commission are exempt from jurisdiction B.

1 (8) Twenty-one ~~Twenty~~ senior public service
2 administrator positions within the Department of
3 Healthcare and Family Services, as set forth in this
4 paragraph (8), requiring the specific knowledge of
5 healthcare administration, healthcare finance, healthcare
6 data analytics, or information technology described are
7 exempt from jurisdiction B only to the extent that the
8 requirements of Sections 8b.1, 8b.3, and 8b.5 of this Code
9 need not be met. The General Assembly finds that these
10 positions are all senior policy makers and have
11 spokesperson authority for the Director of the Department
12 of Healthcare and Family Services. When filling positions
13 so designated, the Director of Healthcare and Family
14 Services shall cause a position description to be published
15 which allots points to various qualifications desired.
16 After scoring qualified applications, the Director shall
17 add Veteran's Preference points as enumerated in Section
18 8b.7 of this Code. The following are the minimum
19 qualifications for the senior public service administrator
20 positions provided for in this paragraph (8):

21 (A) HEALTHCARE ADMINISTRATION.

22 Medical Director: Licensed Medical Doctor in
23 good standing; experience in healthcare payment
24 systems, pay for performance initiatives, medical
25 necessity criteria or federal or State quality
26 improvement programs; preferred experience serving

1 Medicaid patients or experience in population
2 health programs with a large provider, health
3 insurer, government agency, or research
4 institution.

5 Chief, Bureau of Quality Management: Advanced
6 degree in health policy or health professional
7 field preferred; at least 3 years experience in
8 implementing or managing healthcare quality
9 improvement initiatives in a clinical setting.

10 Quality Management Bureau: Manager, Care
11 Coordination/Managed Care Quality: Clinical degree
12 or advanced degree in relevant field required;
13 experience in the field of managed care quality
14 improvement, with knowledge of HEDIS measurements,
15 coding, and related data definitions.

16 Quality Management Bureau: Manager, Primary
17 Care Provider Quality and Practice Development:
18 Clinical degree or advanced degree in relevant
19 field required; experience in practice
20 administration in the primary care setting with a
21 provider or a provider association or an
22 accrediting body; knowledge of practice standards
23 for medical homes and best evidence based
24 standards of care for primary care.

25 Director of Care Coordination Contracts and
26 Compliance: Bachelor's degree required; multi-year

1 experience in negotiating managed care contracts,
2 preferably on behalf of a payer; experience with
3 health care contract compliance.

4 Manager, Long Term Care Policy: Bachelor's
5 degree required; social work, gerontology, or
6 social service degree preferred; knowledge of
7 Olmstead and other relevant court decisions
8 required; experience working with diverse long
9 term care populations and service systems, federal
10 initiatives to create long term care community
11 options, and home and community-based waiver
12 services required. The General Assembly finds that
13 this position is necessary for the timely and
14 effective implementation of this amendatory Act of
15 the 97th General Assembly.

16 Manager, Behavioral Health Programs: Clinical
17 license or Advanced degree required, preferably in
18 psychology, social work, or relevant field;
19 knowledge of medical necessity criteria and
20 governmental policies and regulations governing
21 the provision of mental health services to
22 Medicaid populations, including children and
23 adults, in community and institutional settings of
24 care. The General Assembly finds that this
25 position is necessary for the timely and effective
26 implementation of this amendatory Act of the 97th

1 General Assembly.

2 ~~Chief, Bureau of Pharmacy Services: Bachelor's~~
3 ~~degree required; pharmacy degree preferred; in~~
4 ~~formulary development and management from both a~~
5 ~~clinical and financial perspective, experience in~~
6 ~~prescription drug utilization review and~~
7 ~~utilization control policies, knowledge of retail~~
8 ~~pharmacy reimbursement policies and methodologies~~
9 ~~and available benchmarks, knowledge of Medicare~~
10 ~~Part D benefit design.~~

11 Chief, Bureau of Maternal and Child Health
12 Promotion: Bachelor's degree required, advanced
13 degree preferred, in public health, health care
14 management, or a clinical field; multi-year
15 experience in health care or public health
16 management; knowledge of federal EPSDT
17 requirements and strategies for improving health
18 care for children as well as improving birth
19 outcomes.

20 Director of Dental Program: Bachelor's degree
21 required, advanced degree preferred, in healthcare
22 management or relevant field; experience in
23 healthcare administration; experience in
24 administering dental healthcare programs,
25 knowledge of practice standards for dental care
26 and treatment services; knowledge of the public

1 dental health infrastructure.

2 Manager of Medicare/Medicaid Coordination:
3 Bachelor's degree required, knowledge and
4 experience with Medicare Advantage rules and
5 regulations, knowledge of Medicaid laws and
6 policies; experience with contract drafting
7 preferred.

8 Chief, Bureau of Eligibility Integrity:
9 Bachelor's degree required, advanced degree in
10 public administration or business administration
11 preferred; experience equivalent to 4 years of
12 administration in a public or business
13 organization required; experience with managing
14 contract compliance required; knowledge of
15 Medicaid eligibility laws and policy preferred;
16 supervisory experience preferred. The General
17 Assembly finds that this position is necessary for
18 the timely and effective implementation of this
19 amendatory Act of the 97th General Assembly.

20 (B) HEALTHCARE FINANCE.

21 Director of Care Coordination Rate and
22 Finance: MBA, CPA, or Actuarial degree required;
23 experience in managed care rate setting,
24 including, but not limited to, baseline costs and
25 growth trends; knowledge and experience with
26 Medical Loss Ratio standards and measurements.

1 Director of Encounter Data Program: Bachelor's
2 degree required, advanced degree preferred,
3 preferably in business or information systems; at
4 least 2 years healthcare data reporting
5 experience, including, but not limited to, data
6 definitions, submission, and editing; strong
7 background in HIPAA transactions relevant to
8 encounter data submission; knowledge of healthcare
9 claims systems.

10 Chief, Bureau of Rate Development and
11 Analysis: Bachelor's degree required, advanced
12 degree preferred, with preferred coursework in
13 business or public administration, accounting,
14 finance, data analysis, or statistics; experience
15 with Medicaid reimbursement methodologies and
16 regulations; experience with extracting data from
17 large systems for analysis.

18 Manager of Medical Finance, Division of
19 Finance: Requires relevant advanced degree or
20 certification in relevant field, such as Certified
21 Public Accountant; coursework in business or
22 public administration, accounting, finance, data
23 analysis, or statistics preferred; experience in
24 control systems and GAAP; financial management
25 experience in a healthcare or government entity
26 utilizing Medicaid funding.

1 (C) HEALTHCARE DATA ANALYTICS.

2 Data Quality Assurance Manager: Bachelor's
3 degree required, advanced degree preferred,
4 preferably in business, information systems, or
5 epidemiology; at least 3 years of extensive
6 healthcare data reporting experience with a large
7 provider, health insurer, government agency, or
8 research institution; previous data quality
9 assurance role or formal data quality assurance
10 training.

11 Data Analytics Unit Manager: Bachelor's degree
12 required, advanced degree preferred, in
13 information systems, applied mathematics, or
14 another field with a strong analytics component;
15 extensive healthcare data reporting experience
16 with a large provider, health insurer, government
17 agency, or research institution; experience as a
18 business analyst interfacing between business and
19 information technology departments; in-depth
20 knowledge of health insurance coding and evolving
21 healthcare quality metrics; working knowledge of
22 SQL and/or SAS.

23 Data Analytics Platform Manager: Bachelor's
24 degree required, advanced degree preferred,
25 preferably in business or information systems;
26 extensive healthcare data reporting experience

1 with a large provider, health insurer, government
2 agency, or research institution; previous
3 experience working on a health insurance data
4 analytics platform; experience managing contracts
5 and vendors preferred.

6 (D) HEALTHCARE INFORMATION TECHNOLOGY.

7 ~~Manager of Recipient Provider Reference Unit:~~
8 ~~Bachelor's degree required; experience equivalent~~
9 ~~to 4 years of administration in a public or~~
10 ~~business organization; 3 years of administrative~~
11 ~~experience in a computer based management~~
12 ~~information system.~~

13 Manager of MMIS Claims Unit: Bachelor's degree
14 required, with preferred coursework in business,
15 public administration, information systems;
16 experience equivalent to 4 years of administration
17 in a public or business organization; working
18 knowledge with design and implementation of
19 technical solutions to medical claims payment
20 systems; extensive technical writing experience,
21 including, but not limited to, the development of
22 RFPs, APDs, feasibility studies, and related
23 documents; thorough knowledge of IT system design,
24 commercial off the shelf software packages and
25 hardware components.

26 Assistant Bureau Chief, Office of Information

1 Systems: Bachelor's degree required, with
2 preferred coursework in business, public
3 administration, information systems; experience
4 equivalent to 5 years of administration in a public
5 or private business organization; extensive
6 technical writing experience, including, but not
7 limited to, the development of RFPs, APDs,
8 feasibility studies and related documents;
9 extensive healthcare technology experience with a
10 large provider, health insurer, government agency,
11 or research institution; experience as a business
12 analyst interfacing between business and
13 information technology departments; thorough
14 knowledge of IT system design, commercial off the
15 shelf software packages and hardware components.

16 Technical System Architect: Bachelor's degree
17 required, with preferred coursework in computer
18 science or information technology; prior
19 experience equivalent to 5 years of computer
20 science or IT administration in a public or
21 business organization; extensive healthcare
22 technology experience with a large provider,
23 health insurer, government agency, or research
24 institution; experience as a business analyst
25 interfacing between business and information
26 technology departments.

1 The provisions of this paragraph (8), other than this
2 sentence, are inoperative after January 1, 2014.

3 (Source: P.A. 97-649, eff. 12-30-11.)

4 Section 14. The Illinois State Auditing Act is amended by
5 adding Section 2-20 as follows:

6 (30 ILCS 5/2-20 new)

7 Sec. 2-20. Certification of federal waivers and amendments
8 to the Illinois Title XIX State plan.

9 (a) No later than August 1, 2012, the Department shall file
10 a report with the Auditor General, the Governor, the Speaker of
11 the House of Representatives, the Minority Leader of the House
12 of Representatives, the Senate President, and the Senate
13 Minority Leader listing any necessary amendment to the Illinois
14 Title XIX State plan, federal waiver request, or State
15 administrative rule required to implement this amendatory Act
16 of the 97th General Assembly.

17 (b) No later than March 1, 2013, the Department shall
18 provide evidence to the Auditor General that it has undertaken
19 the required actions listed in the report required by
20 subsection (a).

21 (c) No later than May 1, 2013, the Auditor General shall
22 submit a report to the Governor, the Speaker of the House of
23 Representatives, the Minority Leader of the House of
24 Representatives, the Senate President, and the Senate Minority

1 Leader as to whether the Department has undertaken the required
2 actions listed in the report required by subsection (a).

3 Section 15. The State Finance Act is amended by changing
4 Sections 6z-52, 13.2, and 25 as follows:

5 (30 ILCS 105/6z-52)

6 Sec. 6z-52. Drug Rebate Fund.

7 (a) There is created in the State Treasury a special fund
8 to be known as the Drug Rebate Fund.

9 (b) The Fund is created for the purpose of receiving and
10 disbursing moneys in accordance with this Section.
11 Disbursements from the Fund shall be made, subject to
12 appropriation, only as follows:

13 (1) For payments for reimbursement or coverage for
14 prescription drugs and other pharmacy products provided to
15 a recipient of medical assistance under the Illinois Public
16 Aid Code, the Children's Health Insurance Program Act, the
17 Covering ALL KIDS Health Insurance Act, and the Veterans'
18 Health Insurance Program Act of 2008, ~~and the Senior~~
19 ~~Citizens and Disabled Persons Property Tax Relief and~~
20 ~~Pharmaceutical Assistance Act.~~

21 (2) For reimbursement of moneys collected by the
22 Department of Healthcare and Family Services (formerly
23 Illinois Department of Public Aid) through error or
24 mistake.

1 (3) For payments of any amounts that are reimbursable
2 to the federal government resulting from a payment into
3 this Fund.

4 (4) For payments of operational and administrative
5 expenses related to providing and managing coverage for
6 prescription drugs and other pharmacy products provided to
7 a recipient of medical assistance under the Illinois Public
8 Aid Code, the Children's Health Insurance Program Act, the
9 Covering ALL KIDS Health Insurance Act, the Veterans'
10 Health Insurance Program Act of 2008, and the Senior
11 Citizens and Disabled Persons Property Tax Relief and
12 Pharmaceutical Assistance Act.

13 (c) The Fund shall consist of the following:

14 (1) Upon notification from the Director of Healthcare
15 and Family Services, the Comptroller shall direct and the
16 Treasurer shall transfer the net State share (disregarding
17 the reduction in net State share attributable to the
18 American Recovery and Reinvestment Act of 2009 or any other
19 federal economic stimulus program) of all moneys received
20 by the Department of Healthcare and Family Services
21 (formerly Illinois Department of Public Aid) from drug
22 rebate agreements with pharmaceutical manufacturers
23 pursuant to Title XIX of the federal Social Security Act,
24 including any portion of the balance in the Public Aid
25 Recoveries Trust Fund on July 1, 2001 that is attributable
26 to such receipts.

1 (2) All federal matching funds received by the Illinois
2 Department as a result of expenditures made by the
3 Department that are attributable to moneys deposited in the
4 Fund.

5 (3) Any premium collected by the Illinois Department
6 from participants under a waiver approved by the federal
7 government relating to provision of pharmaceutical
8 services.

9 (4) All other moneys received for the Fund from any
10 other source, including interest earned thereon.

11 (Source: P.A. 95-331, eff. 8-21-07; 96-8, eff. 4-28-09;
12 96-1100, eff. 1-1-11.)

13 (30 ILCS 105/13.2) (from Ch. 127, par. 149.2)

14 Sec. 13.2. Transfers among line item appropriations.

15 (a) Transfers among line item appropriations from the same
16 treasury fund for the objects specified in this Section may be
17 made in the manner provided in this Section when the balance
18 remaining in one or more such line item appropriations is
19 insufficient for the purpose for which the appropriation was
20 made.

21 (a-1) No transfers may be made from one agency to another
22 agency, nor may transfers be made from one institution of
23 higher education to another institution of higher education
24 except as provided by subsection (a-4).

25 (a-2) Except as otherwise provided in this Section,

1 transfers may be made only among the objects of expenditure
2 enumerated in this Section, except that no funds may be
3 transferred from any appropriation for personal services, from
4 any appropriation for State contributions to the State
5 Employees' Retirement System, from any separate appropriation
6 for employee retirement contributions paid by the employer, nor
7 from any appropriation for State contribution for employee
8 group insurance. During State fiscal year 2005, an agency may
9 transfer amounts among its appropriations within the same
10 treasury fund for personal services, employee retirement
11 contributions paid by employer, and State Contributions to
12 retirement systems; notwithstanding and in addition to the
13 transfers authorized in subsection (c) of this Section, the
14 fiscal year 2005 transfers authorized in this sentence may be
15 made in an amount not to exceed 2% of the aggregate amount
16 appropriated to an agency within the same treasury fund. During
17 State fiscal year 2007, the Departments of Children and Family
18 Services, Corrections, Human Services, and Juvenile Justice
19 may transfer amounts among their respective appropriations
20 within the same treasury fund for personal services, employee
21 retirement contributions paid by employer, and State
22 contributions to retirement systems. During State fiscal year
23 2010, the Department of Transportation may transfer amounts
24 among their respective appropriations within the same treasury
25 fund for personal services, employee retirement contributions
26 paid by employer, and State contributions to retirement

1 systems. During State fiscal year 2010 only, an agency may
2 transfer amounts among its respective appropriations within
3 the same treasury fund for personal services, employee
4 retirement contributions paid by employer, and State
5 contributions to retirement systems. Notwithstanding, and in
6 addition to, the transfers authorized in subsection (c) of this
7 Section, these transfers may be made in an amount not to exceed
8 2% of the aggregate amount appropriated to an agency within the
9 same treasury fund.

10 (a-3) Further, if an agency receives a separate
11 appropriation for employee retirement contributions paid by
12 the employer, any transfer by that agency into an appropriation
13 for personal services must be accompanied by a corresponding
14 transfer into the appropriation for employee retirement
15 contributions paid by the employer, in an amount sufficient to
16 meet the employer share of the employee contributions required
17 to be remitted to the retirement system.

18 (a-4) Long-Term Care Rebalancing. The Governor may
19 designate amounts set aside for institutional services
20 appropriated from the General Revenue Fund or any other State
21 fund that receives monies for long-term care services to be
22 transferred to all State agencies responsible for the
23 administration of community-based long-term care programs,
24 including, but not limited to, community-based long-term care
25 programs administered by the Department of Healthcare and
26 Family Services, the Department of Human Services, and the

1 Department on Aging, provided that the Director of Healthcare
2 and Family Services first certifies that the amounts being
3 transferred are necessary for the purpose of assisting persons
4 in or at risk of being in institutional care to transition to
5 community-based settings, including the financial data needed
6 to prove the need for the transfer of funds. The total amounts
7 transferred shall not exceed 4% in total of the amounts
8 appropriated from the General Revenue Fund or any other State
9 fund that receives monies for long-term care services for each
10 fiscal year. A notice of the fund transfer must be made to the
11 General Assembly and posted at a minimum on the Department of
12 Healthcare and Family Services website, the Governor's Office
13 of Management and Budget website, and any other website the
14 Governor sees fit. These postings shall serve as notice to the
15 General Assembly of the amounts to be transferred. Notice shall
16 be given at least 30 days prior to transfer.

17 (b) In addition to the general transfer authority provided
18 under subsection (c), the following agencies have the specific
19 transfer authority granted in this subsection:

20 The Department of Healthcare and Family Services is
21 authorized to make transfers representing savings attributable
22 to not increasing grants due to the births of additional
23 children from line items for payments of cash grants to line
24 items for payments for employment and social services for the
25 purposes outlined in subsection (f) of Section 4-2 of the
26 Illinois Public Aid Code.

1 The Department of Children and Family Services is
2 authorized to make transfers not exceeding 2% of the aggregate
3 amount appropriated to it within the same treasury fund for the
4 following line items among these same line items: Foster Home
5 and Specialized Foster Care and Prevention, Institutions and
6 Group Homes and Prevention, and Purchase of Adoption and
7 Guardianship Services.

8 The Department on Aging is authorized to make transfers not
9 exceeding 2% of the aggregate amount appropriated to it within
10 the same treasury fund for the following Community Care Program
11 line items among these same line items: Homemaker and Senior
12 Companion Services, Alternative Senior Services, Case
13 Coordination Units, and Adult Day Care Services.

14 The State Treasurer is authorized to make transfers among
15 line item appropriations from the Capital Litigation Trust
16 Fund, with respect to costs incurred in fiscal years 2002 and
17 2003 only, when the balance remaining in one or more such line
18 item appropriations is insufficient for the purpose for which
19 the appropriation was made, provided that no such transfer may
20 be made unless the amount transferred is no longer required for
21 the purpose for which that appropriation was made.

22 The State Board of Education is authorized to make
23 transfers from line item appropriations within the same
24 treasury fund for General State Aid and General State Aid -
25 Hold Harmless, provided that no such transfer may be made
26 unless the amount transferred is no longer required for the

1 purpose for which that appropriation was made, to the line item
2 appropriation for Transitional Assistance when the balance
3 remaining in such line item appropriation is insufficient for
4 the purpose for which the appropriation was made.

5 The State Board of Education is authorized to make
6 transfers between the following line item appropriations
7 within the same treasury fund: Disabled Student
8 Services/Materials (Section 14-13.01 of the School Code),
9 Disabled Student Transportation Reimbursement (Section
10 14-13.01 of the School Code), Disabled Student Tuition -
11 Private Tuition (Section 14-7.02 of the School Code),
12 Extraordinary Special Education (Section 14-7.02b of the
13 School Code), Reimbursement for Free Lunch/Breakfast Program,
14 Summer School Payments (Section 18-4.3 of the School Code), and
15 Transportation - Regular/Vocational Reimbursement (Section
16 29-5 of the School Code). Such transfers shall be made only
17 when the balance remaining in one or more such line item
18 appropriations is insufficient for the purpose for which the
19 appropriation was made and provided that no such transfer may
20 be made unless the amount transferred is no longer required for
21 the purpose for which that appropriation was made.

22 ~~The During State fiscal years 2010 and 2011 only, the~~
23 Department of Healthcare and Family Services is authorized to
24 make transfers not exceeding 4% of the aggregate amount
25 appropriated to it, within the same treasury fund, among the
26 various line items appropriated for Medical Assistance.

1 (c) The sum of such transfers for an agency in a fiscal
2 year shall not exceed 2% of the aggregate amount appropriated
3 to it within the same treasury fund for the following objects:
4 Personal Services; Extra Help; Student and Inmate
5 Compensation; State Contributions to Retirement Systems; State
6 Contributions to Social Security; State Contribution for
7 Employee Group Insurance; Contractual Services; Travel;
8 Commodities; Printing; Equipment; Electronic Data Processing;
9 Operation of Automotive Equipment; Telecommunications
10 Services; Travel and Allowance for Committed, Paroled and
11 Discharged Prisoners; Library Books; Federal Matching Grants
12 for Student Loans; Refunds; Workers' Compensation,
13 Occupational Disease, and Tort Claims; and, in appropriations
14 to institutions of higher education, Awards and Grants.
15 Notwithstanding the above, any amounts appropriated for
16 payment of workers' compensation claims to an agency to which
17 the authority to evaluate, administer and pay such claims has
18 been delegated by the Department of Central Management Services
19 may be transferred to any other expenditure object where such
20 amounts exceed the amount necessary for the payment of such
21 claims.

22 (c-1) Special provisions for State fiscal year 2003.
23 Notwithstanding any other provision of this Section to the
24 contrary, for State fiscal year 2003 only, transfers among line
25 item appropriations to an agency from the same treasury fund
26 may be made provided that the sum of such transfers for an

1 agency in State fiscal year 2003 shall not exceed 3% of the
2 aggregate amount appropriated to that State agency for State
3 fiscal year 2003 for the following objects: personal services,
4 except that no transfer may be approved which reduces the
5 aggregate appropriations for personal services within an
6 agency; extra help; student and inmate compensation; State
7 contributions to retirement systems; State contributions to
8 social security; State contributions for employee group
9 insurance; contractual services; travel; commodities;
10 printing; equipment; electronic data processing; operation of
11 automotive equipment; telecommunications services; travel and
12 allowance for committed, paroled, and discharged prisoners;
13 library books; federal matching grants for student loans;
14 refunds; workers' compensation, occupational disease, and tort
15 claims; and, in appropriations to institutions of higher
16 education, awards and grants.

17 (c-2) Special provisions for State fiscal year 2005.
18 Notwithstanding subsections (a), (a-2), and (c), for State
19 fiscal year 2005 only, transfers may be made among any line
20 item appropriations from the same or any other treasury fund
21 for any objects or purposes, without limitation, when the
22 balance remaining in one or more such line item appropriations
23 is insufficient for the purpose for which the appropriation was
24 made, provided that the sum of those transfers by a State
25 agency shall not exceed 4% of the aggregate amount appropriated
26 to that State agency for fiscal year 2005.

1 (d) Transfers among appropriations made to agencies of the
2 Legislative and Judicial departments and to the
3 constitutionally elected officers in the Executive branch
4 require the approval of the officer authorized in Section 10 of
5 this Act to approve and certify vouchers. Transfers among
6 appropriations made to the University of Illinois, Southern
7 Illinois University, Chicago State University, Eastern
8 Illinois University, Governors State University, Illinois
9 State University, Northeastern Illinois University, Northern
10 Illinois University, Western Illinois University, the Illinois
11 Mathematics and Science Academy and the Board of Higher
12 Education require the approval of the Board of Higher Education
13 and the Governor. Transfers among appropriations to all other
14 agencies require the approval of the Governor.

15 The officer responsible for approval shall certify that the
16 transfer is necessary to carry out the programs and purposes
17 for which the appropriations were made by the General Assembly
18 and shall transmit to the State Comptroller a certified copy of
19 the approval which shall set forth the specific amounts
20 transferred so that the Comptroller may change his records
21 accordingly. The Comptroller shall furnish the Governor with
22 information copies of all transfers approved for agencies of
23 the Legislative and Judicial departments and transfers
24 approved by the constitutionally elected officials of the
25 Executive branch other than the Governor, showing the amounts
26 transferred and indicating the dates such changes were entered

1 on the Comptroller's records.

2 (e) The State Board of Education, in consultation with the
3 State Comptroller, may transfer line item appropriations for
4 General State Aid between the Common School Fund and the
5 Education Assistance Fund. With the advice and consent of the
6 Governor's Office of Management and Budget, the State Board of
7 Education, in consultation with the State Comptroller, may
8 transfer line item appropriations between the General Revenue
9 Fund and the Education Assistance Fund for the following
10 programs:

11 (1) Disabled Student Personnel Reimbursement (Section
12 14-13.01 of the School Code);

13 (2) Disabled Student Transportation Reimbursement
14 (subsection (b) of Section 14-13.01 of the School Code);

15 (3) Disabled Student Tuition - Private Tuition
16 (Section 14-7.02 of the School Code);

17 (4) Extraordinary Special Education (Section 14-7.02b
18 of the School Code);

19 (5) Reimbursement for Free Lunch/Breakfast Programs;

20 (6) Summer School Payments (Section 18-4.3 of the
21 School Code);

22 (7) Transportation - Regular/Vocational Reimbursement
23 (Section 29-5 of the School Code);

24 (8) Regular Education Reimbursement (Section 18-3 of
25 the School Code); and

26 (9) Special Education Reimbursement (Section 14-7.03

1 of the School Code).

2 (Source: P.A. 95-707, eff. 1-11-08; 96-37, eff. 7-13-09;
3 96-820, eff. 11-18-09; 96-959, eff. 7-1-10; 96-1086, eff.
4 7-16-10; 96-1501, eff. 1-25-11.)

5 (30 ILCS 105/25) (from Ch. 127, par. 161)

6 Sec. 25. Fiscal year limitations.

7 (a) All appropriations shall be available for expenditure
8 for the fiscal year or for a lesser period if the Act making
9 that appropriation so specifies. A deficiency or emergency
10 appropriation shall be available for expenditure only through
11 June 30 of the year when the Act making that appropriation is
12 enacted unless that Act otherwise provides.

13 (b) Outstanding liabilities as of June 30, payable from
14 appropriations which have otherwise expired, may be paid out of
15 the expiring appropriations during the 2-month period ending at
16 the close of business on August 31. Any service involving
17 professional or artistic skills or any personal services by an
18 employee whose compensation is subject to income tax
19 withholding must be performed as of June 30 of the fiscal year
20 in order to be considered an "outstanding liability as of June
21 30" that is thereby eligible for payment out of the expiring
22 appropriation.

23 (b-1) However, payment of tuition reimbursement claims
24 under Section 14-7.03 or 18-3 of the School Code may be made by
25 the State Board of Education from its appropriations for those

1 respective purposes for any fiscal year, even though the claims
2 reimbursed by the payment may be claims attributable to a prior
3 fiscal year, and payments may be made at the direction of the
4 State Superintendent of Education from the fund from which the
5 appropriation is made without regard to any fiscal year
6 limitations, except as required by subsection (j) of this
7 Section. Beginning on June 30, 2021, payment of tuition
8 reimbursement claims under Section 14-7.03 or 18-3 of the
9 School Code as of June 30, payable from appropriations that
10 have otherwise expired, may be paid out of the expiring
11 appropriation during the 4-month period ending at the close of
12 business on October 31.

13 (b-2) All outstanding liabilities as of June 30, 2010,
14 payable from appropriations that would otherwise expire at the
15 conclusion of the lapse period for fiscal year 2010, and
16 interest penalties payable on those liabilities under the State
17 Prompt Payment Act, may be paid out of the expiring
18 appropriations until December 31, 2010, without regard to the
19 fiscal year in which the payment is made, as long as vouchers
20 for the liabilities are received by the Comptroller no later
21 than August 31, 2010.

22 (b-2.5) All outstanding liabilities as of June 30, 2011,
23 payable from appropriations that would otherwise expire at the
24 conclusion of the lapse period for fiscal year 2011, and
25 interest penalties payable on those liabilities under the State
26 Prompt Payment Act, may be paid out of the expiring

1 appropriations until December 31, 2011, without regard to the
2 fiscal year in which the payment is made, as long as vouchers
3 for the liabilities are received by the Comptroller no later
4 than August 31, 2011.

5 (b-3) Medical payments may be made by the Department of
6 Veterans' Affairs from its appropriations for those purposes
7 for any fiscal year, without regard to the fact that the
8 medical services being compensated for by such payment may have
9 been rendered in a prior fiscal year, except as required by
10 subsection (j) of this Section. Beginning on June 30, 2021,
11 medical payments payable from appropriations that have
12 otherwise expired may be paid out of the expiring appropriation
13 during the 4-month period ending at the close of business on
14 October 31.

15 (b-4) Medical payments ~~may be made by the Department of~~
16 ~~Healthcare and Family Services and medical payments~~ and child
17 care payments may be made by the Department of Human Services
18 (as successor to the Department of Public Aid) from
19 appropriations for those purposes for any fiscal year, without
20 regard to the fact that the medical or child care services
21 being compensated for by such payment may have been rendered in
22 a prior fiscal year; and payments may be made at the direction
23 of the Department of Healthcare and Family Services (or
24 successor agency) from the Health Insurance Reserve Fund ~~and~~
25 ~~the Local Government Health Insurance Reserve Fund~~ without
26 regard to any fiscal year limitations, except as required by

1 subsection (j) of this Section. Beginning on June 30, 2021,
2 medical and ~~payments made by the Department of Healthcare and~~
3 ~~Family Services,~~ child care payments made by the Department of
4 Human Services, and payments made at the discretion of the
5 Department of Healthcare and Family Services (or successor
6 agency) from the Health Insurance Reserve Fund and ~~the Local~~
7 ~~Government Health Insurance Reserve Fund~~ payable from
8 appropriations that have otherwise expired may be paid out of
9 the expiring appropriation during the 4-month period ending at
10 the close of business on October 31.

11 (b-5) Medical payments may be made by the Department of
12 Human Services from its appropriations relating to substance
13 abuse treatment services for any fiscal year, without regard to
14 the fact that the medical services being compensated for by
15 such payment may have been rendered in a prior fiscal year,
16 provided the payments are made on a fee-for-service basis
17 consistent with requirements established for Medicaid
18 reimbursement by the Department of Healthcare and Family
19 Services, except as required by subsection (j) of this Section.
20 Beginning on June 30, 2021, medical payments made by the
21 Department of Human Services relating to substance abuse
22 treatment services payable from appropriations that have
23 otherwise expired may be paid out of the expiring appropriation
24 during the 4-month period ending at the close of business on
25 October 31.

26 (b-6) Additionally, payments may be made by the Department

1 of Human Services from its appropriations, or any other State
2 agency from its appropriations with the approval of the
3 Department of Human Services, from the Immigration Reform and
4 Control Fund for purposes authorized pursuant to the
5 Immigration Reform and Control Act of 1986, without regard to
6 any fiscal year limitations, except as required by subsection
7 (j) of this Section. Beginning on June 30, 2021, payments made
8 by the Department of Human Services from the Immigration Reform
9 and Control Fund for purposes authorized pursuant to the
10 Immigration Reform and Control Act of 1986 payable from
11 appropriations that have otherwise expired may be paid out of
12 the expiring appropriation during the 4-month period ending at
13 the close of business on October 31.

14 (b-7) Payments may be made in accordance with a plan
15 authorized by paragraph (11) or (12) of Section 405-105 of the
16 Department of Central Management Services Law from
17 appropriations for those payments without regard to fiscal year
18 limitations.

19 (c) Further, payments may be made by the Department of
20 Public Health and ~~the~~ Department of Human Services (acting as
21 successor to the Department of Public Health under the
22 Department of Human Services Act), ~~and the Department of~~
23 ~~Healthcare and Family Services~~ from their respective
24 appropriations for grants for medical care to or on behalf of
25 ~~persons suffering from chronic renal disease, persons~~
26 ~~suffering from hemophilia, rape victims, and premature and~~

1 high-mortality risk infants and their mothers and for grants
2 for supplemental food supplies provided under the United States
3 Department of Agriculture Women, Infants and Children
4 Nutrition Program, for any fiscal year without regard to the
5 fact that the services being compensated for by such payment
6 may have been rendered in a prior fiscal year, except as
7 required by subsection (j) of this Section. Beginning on June
8 30, 2021, payments made by the Department of Public Health and
9 ~~the Department of Human Services, and the Department of~~
10 ~~Healthcare and Family Services~~ from their respective
11 appropriations for grants for medical care to or on behalf of
12 ~~persons suffering from chronic renal disease, persons~~
13 ~~suffering from hemophilia, rape victims, and~~ premature and
14 high-mortality risk infants and their mothers and for grants
15 for supplemental food supplies provided under the United States
16 Department of Agriculture Women, Infants and Children
17 Nutrition Program payable from appropriations that have
18 otherwise expired may be paid out of the expiring
19 appropriations during the 4-month period ending at the close of
20 business on October 31.

21 (d) The Department of Public Health and the Department of
22 Human Services (acting as successor to the Department of Public
23 Health under the Department of Human Services Act) shall each
24 annually submit to the State Comptroller, Senate President,
25 Senate Minority Leader, Speaker of the House, House Minority
26 Leader, and the respective Chairmen and Minority Spokesmen of

1 the Appropriations Committees of the Senate and the House, on
2 or before December 31, a report of fiscal year funds used to
3 pay for services provided in any prior fiscal year. This report
4 shall document by program or service category those
5 expenditures from the most recently completed fiscal year used
6 to pay for services provided in prior fiscal years.

7 (e) The Department of Healthcare and Family Services, the
8 Department of Human Services (acting as successor to the
9 Department of Public Aid), and the Department of Human Services
10 making fee-for-service payments relating to substance abuse
11 treatment services provided during a previous fiscal year shall
12 each annually submit to the State Comptroller, Senate
13 President, Senate Minority Leader, Speaker of the House, House
14 Minority Leader, the respective Chairmen and Minority
15 Spokesmen of the Appropriations Committees of the Senate and
16 the House, on or before November 30, a report that shall
17 document by program or service category those expenditures from
18 the most recently completed fiscal year used to pay for (i)
19 services provided in prior fiscal years and (ii) services for
20 which claims were received in prior fiscal years.

21 (f) The Department of Human Services (as successor to the
22 Department of Public Aid) shall annually submit to the State
23 Comptroller, Senate President, Senate Minority Leader, Speaker
24 of the House, House Minority Leader, and the respective
25 Chairmen and Minority Spokesmen of the Appropriations
26 Committees of the Senate and the House, on or before December

1 31, a report of fiscal year funds used to pay for services
2 (other than medical care) provided in any prior fiscal year.
3 This report shall document by program or service category those
4 expenditures from the most recently completed fiscal year used
5 to pay for services provided in prior fiscal years.

6 (g) In addition, each annual report required to be
7 submitted by the Department of Healthcare and Family Services
8 under subsection (e) shall include the following information
9 with respect to the State's Medicaid program:

10 (1) Explanations of the exact causes of the variance
11 between the previous year's estimated and actual
12 liabilities.

13 (2) Factors affecting the Department of Healthcare and
14 Family Services' liabilities, including but not limited to
15 numbers of aid recipients, levels of medical service
16 utilization by aid recipients, and inflation in the cost of
17 medical services.

18 (3) The results of the Department's efforts to combat
19 fraud and abuse.

20 (h) As provided in Section 4 of the General Assembly
21 Compensation Act, any utility bill for service provided to a
22 General Assembly member's district office for a period
23 including portions of 2 consecutive fiscal years may be paid
24 from funds appropriated for such expenditure in either fiscal
25 year.

26 (i) An agency which administers a fund classified by the

1 Comptroller as an internal service fund may issue rules for:

2 (1) billing user agencies in advance for payments or
3 authorized inter-fund transfers based on estimated charges
4 for goods or services;

5 (2) issuing credits, refunding through inter-fund
6 transfers, or reducing future inter-fund transfers during
7 the subsequent fiscal year for all user agency payments or
8 authorized inter-fund transfers received during the prior
9 fiscal year which were in excess of the final amounts owed
10 by the user agency for that period; and

11 (3) issuing catch-up billings to user agencies during
12 the subsequent fiscal year for amounts remaining due when
13 payments or authorized inter-fund transfers received from
14 the user agency during the prior fiscal year were less than
15 the total amount owed for that period.

16 User agencies are authorized to reimburse internal service
17 funds for catch-up billings by vouchers drawn against their
18 respective appropriations for the fiscal year in which the
19 catch-up billing was issued or by increasing an authorized
20 inter-fund transfer during the current fiscal year. For the
21 purposes of this Act, "inter-fund transfers" means transfers
22 without the use of the voucher-warrant process, as authorized
23 by Section 9.01 of the State Comptroller Act.

24 (i-1) Beginning on July 1, 2021, all outstanding
25 liabilities, not payable during the 4-month lapse period as
26 described in subsections (b-1), (b-3), (b-4), (b-5), (b-6), and

1 (c) of this Section, that are made from appropriations for that
2 purpose for any fiscal year, without regard to the fact that
3 the services being compensated for by those payments may have
4 been rendered in a prior fiscal year, are limited to only those
5 claims that have been incurred but for which a proper bill or
6 invoice as defined by the State Prompt Payment Act has not been
7 received by September 30th following the end of the fiscal year
8 in which the service was rendered.

9 (j) Notwithstanding any other provision of this Act, the
10 aggregate amount of payments to be made without regard for
11 fiscal year limitations as contained in subsections (b-1),
12 (b-3), (b-4), (b-5), (b-6), and (c) of this Section, and
13 determined by using Generally Accepted Accounting Principles,
14 shall not exceed the following amounts:

15 (1) \$6,000,000,000 for outstanding liabilities related
16 to fiscal year 2012;

17 (2) \$5,300,000,000 for outstanding liabilities related
18 to fiscal year 2013;

19 (3) \$4,600,000,000 for outstanding liabilities related
20 to fiscal year 2014;

21 (4) \$4,000,000,000 for outstanding liabilities related
22 to fiscal year 2015;

23 (5) \$3,300,000,000 for outstanding liabilities related
24 to fiscal year 2016;

25 (6) \$2,600,000,000 for outstanding liabilities related
26 to fiscal year 2017;

1 (7) \$2,000,000,000 for outstanding liabilities related
2 to fiscal year 2018;

3 (8) \$1,300,000,000 for outstanding liabilities related
4 to fiscal year 2019;

5 (9) \$600,000,000 for outstanding liabilities related
6 to fiscal year 2020; and

7 (10) \$0 for outstanding liabilities related to fiscal
8 year 2021 and fiscal years thereafter.

9 (k) Department of Healthcare and Family Services Medical
10 Assistance Payments.

11 (1) Definition of Medical Assistance.

12 For purposes of this subsection, the term "Medical
13 Assistance" shall include, but not necessarily be
14 limited to, medical programs and services authorized
15 under Titles XIX and XXI of the Social Security Act,
16 the Illinois Public Aid Code, the Children's Health
17 Insurance Program Act, the Covering ALL KIDS Health
18 Insurance Act, the Long Term Acute Care Hospital
19 Quality Improvement Transfer Program Act, and medical
20 care to or on behalf of persons suffering from chronic
21 renal disease, persons suffering from hemophilia and
22 victims of sexual assault.

23 (2) Limitations on Medical Assistance payments that
24 may be paid from future fiscal year appropriations.

25 (A) The maximum amounts of annual unpaid Medical
26 Assistance bills received and recorded by the

1 Department of Healthcare and Family Services on or
2 before June 30th of a particular fiscal year
3 attributable in aggregate to the General Revenue Fund,
4 Healthcare Provider Relief Fund, Tobacco Settlement
5 Recovery Fund, Long-Term Care Provider Fund, and the
6 Drug Rebate Fund that may be paid in total by the
7 Department from future fiscal year Medical Assistance
8 appropriations to those funds are: \$700,000,000 for
9 fiscal year 2013 and \$100,000,000 for fiscal year 2014
10 and each fiscal year thereafter.

11 (B) Bills for Medical Assistance services rendered
12 in a particular fiscal year, but received and recorded
13 by the Department of Healthcare and Family Services
14 after June 30th of that fiscal year, may be paid from
15 either appropriations for that fiscal year or future
16 fiscal year appropriations for Medical Assistance.
17 Such payments shall not be subject to the requirements
18 of subparagraph (A).

19 (C) Medical Assistance bills received by the
20 Department of Healthcare and Family Services in a
21 particular fiscal year, but subject to payment amount
22 adjustments in a future fiscal year may be paid from a
23 future fiscal year's appropriation for Medical
24 Assistance. Such payments shall not be subject to the
25 requirements of subparagraph (A).

26 (D) Medical Assistance payments made by the

1 Department of Healthcare and Family Services from
2 funds other than those specifically referenced in
3 subparagraph (A) may be made from appropriations for
4 those purposes for any fiscal year without regard to
5 the fact that the Medical Assistance services being
6 compensated for by such payment may have been rendered
7 in a prior fiscal year. Such payments shall not be
8 subject to the requirements of subparagraph (A).

9 (3) Extended lapse period for Department of Healthcare
10 and Family Services Medical Assistance payments.
11 Notwithstanding any other State law to the contrary,
12 outstanding Department of Healthcare and Family Services
13 Medical Assistance liabilities, as of June 30th, payable
14 from appropriations which have otherwise expired, may be
15 paid out of the expiring appropriations during the 6-month
16 period ending at the close of business on December 31st.

17 (1) The changes to this Section made by this amendatory Act
18 of the 97th General Assembly shall be effective for payment of
19 Medical Assistance bills incurred in fiscal year 2013 and
20 future fiscal years. The changes to this Section made by this
21 amendatory Act of the 97th General Assembly shall not be
22 applied to Medical Assistance bills incurred in fiscal year
23 2012 or prior fiscal years.

24 (Source: P.A. 96-928, eff. 6-15-10; 96-958, eff. 7-1-10;
25 96-1501, eff. 1-25-11; 97-75, eff. 6-30-11; 97-333, eff.
26 8-12-11.)

1 (30 ILCS 105/5.441 rep.)

2 (30 ILCS 105/5.442 rep.)

3 (30 ILCS 105/5.549 rep.)

4 Section 20. The State Finance Act is amended by repealing
5 Sections 5.441, 5.442, and 5.549.

6 Section 25. The Illinois Procurement Code is amended by
7 changing Section 1-10 as follows:

8 (30 ILCS 500/1-10)

9 Sec. 1-10. Application.

10 (a) This Code applies only to procurements for which
11 contractors were first solicited on or after July 1, 1998. This
12 Code shall not be construed to affect or impair any contract,
13 or any provision of a contract, entered into based on a
14 solicitation prior to the implementation date of this Code as
15 described in Article 99, including but not limited to any
16 covenant entered into with respect to any revenue bonds or
17 similar instruments. All procurements for which contracts are
18 solicited between the effective date of Articles 50 and 99 and
19 July 1, 1998 shall be substantially in accordance with this
20 Code and its intent.

21 (b) This Code shall apply regardless of the source of the
22 funds with which the contracts are paid, including federal
23 assistance moneys. This Code shall not apply to:

1 (1) Contracts between the State and its political
2 subdivisions or other governments, or between State
3 governmental bodies except as specifically provided in
4 this Code.

5 (2) Grants, except for the filing requirements of
6 Section 20-80.

7 (3) Purchase of care.

8 (4) Hiring of an individual as employee and not as an
9 independent contractor, whether pursuant to an employment
10 code or policy or by contract directly with that
11 individual.

12 (5) Collective bargaining contracts.

13 (6) Purchase of real estate, except that notice of this
14 type of contract with a value of more than \$25,000 must be
15 published in the Procurement Bulletin within 7 days after
16 the deed is recorded in the county of jurisdiction. The
17 notice shall identify the real estate purchased, the names
18 of all parties to the contract, the value of the contract,
19 and the effective date of the contract.

20 (7) Contracts necessary to prepare for anticipated
21 litigation, enforcement actions, or investigations,
22 provided that the chief legal counsel to the Governor shall
23 give his or her prior approval when the procuring agency is
24 one subject to the jurisdiction of the Governor, and
25 provided that the chief legal counsel of any other
26 procuring entity subject to this Code shall give his or her

1 prior approval when the procuring entity is not one subject
2 to the jurisdiction of the Governor.

3 (8) Contracts for services to Northern Illinois
4 University by a person, acting as an independent
5 contractor, who is qualified by education, experience, and
6 technical ability and is selected by negotiation for the
7 purpose of providing non-credit educational service
8 activities or products by means of specialized programs
9 offered by the university.

10 (9) Procurement expenditures by the Illinois
11 Conservation Foundation when only private funds are used.

12 (10) Procurement expenditures by the Illinois Health
13 Information Exchange Authority involving private funds
14 from the Health Information Exchange Fund. "Private funds"
15 means gifts, donations, and private grants.

16 (11) Public-private agreements entered into according
17 to the procurement requirements of Section 20 of the
18 Public-Private Partnerships for Transportation Act and
19 design-build agreements entered into according to the
20 procurement requirements of Section 25 of the
21 Public-Private Partnerships for Transportation Act.

22 (c) This Code does not apply to the electric power
23 procurement process provided for under Section 1-75 of the
24 Illinois Power Agency Act and Section 16-111.5 of the Public
25 Utilities Act.

26 (d) Except for Section 20-160 and Article 50 of this Code,

1 and as expressly required by Section 9.1 of the Illinois
2 Lottery Law, the provisions of this Code do not apply to the
3 procurement process provided for under Section 9.1 of the
4 Illinois Lottery Law.

5 (e) This Code does not apply to the process used by the
6 Capital Development Board to retain a person or entity to
7 assist the Capital Development Board with its duties related to
8 the determination of costs of a clean coal SNG brownfield
9 facility, as defined by Section 1-10 of the Illinois Power
10 Agency Act, as required in subsection (h-3) of Section 9-220 of
11 the Public Utilities Act, including calculating the range of
12 capital costs, the range of operating and maintenance costs, or
13 the sequestration costs or monitoring the construction of clean
14 coal SNG brownfield facility for the full duration of
15 construction.

16 (f) This Code does not apply to the process used by the
17 Illinois Power Agency to retain a mediator to mediate sourcing
18 agreement disputes between gas utilities and the clean coal SNG
19 brownfield facility, as defined in Section 1-10 of the Illinois
20 Power Agency Act, as required under subsection (h-1) of Section
21 9-220 of the Public Utilities Act.

22 (g) ~~(e)~~ This Code does not apply to the processes used by
23 the Illinois Power Agency to retain a mediator to mediate
24 contract disputes between gas utilities and the clean coal SNG
25 facility and to retain an expert to assist in the review of
26 contracts under subsection (h) of Section 9-220 of the Public

1 Utilities Act. This Code does not apply to the process used by
2 the Illinois Commerce Commission to retain an expert to assist
3 in determining the actual incurred costs of the clean coal SNG
4 facility and the reasonableness of those costs as required
5 under subsection (h) of Section 9-220 of the Public Utilities
6 Act.

7 (h) This Code does not apply to the process to procure or
8 contracts entered into in accordance with Sections 11-5.2 and
9 11-5.3 of the Illinois Public Aid Code.

10 (Source: P.A. 96-840, eff. 12-23-09; 96-1331, eff. 7-27-10;
11 97-96, eff. 7-13-11; 97-239, eff. 8-2-11; 97-502, eff. 8-23-11;
12 revised 9-7-11.)

13 (30 ILCS 775/Act rep.)

14 Section 30. The Excellence in Academic Medicine Act is
15 repealed.

16 Section 45. The Nursing Home Care Act is amended by
17 changing Section 3-202.05 as follows:

18 (210 ILCS 45/3-202.05)

19 Sec. 3-202.05. Staffing ratios effective July 1, 2010 and
20 thereafter.

21 (a) For the purpose of computing staff to resident ratios,
22 direct care staff shall include:

23 (1) registered nurses;

- 1 (2) licensed practical nurses;
- 2 (3) certified nurse assistants;
- 3 (4) psychiatric services rehabilitation aides;
- 4 (5) rehabilitation and therapy aides;
- 5 (6) psychiatric services rehabilitation coordinators;
- 6 (7) assistant directors of nursing;
- 7 (8) 50% of the Director of Nurses' time; and
- 8 (9) 30% of the Social Services Directors' time.

9 The Department shall, by rule, allow certain facilities
10 subject to 77 Ill. Admin. Code 300.4000 and following (Subpart
11 S) ~~and 300.6000 and following (Subpart T)~~ to utilize
12 specialized clinical staff, as defined in rules, to count
13 towards the staffing ratios.

14 Within 120 days of the effective date of this amendatory
15 Act of the 97th General Assembly, the Department shall
16 promulgate rules specific to the staffing requirements for
17 facilities federally defined as Institutions for Mental
18 Disease. These rules shall recognize the unique nature of
19 individuals with chronic mental health conditions, shall
20 include minimum requirements for specialized clinical staff,
21 including clinical social workers, psychiatrists,
22 psychologists, and direct care staff set forth in paragraphs
23 (4) through (6) and any other specialized staff which may be
24 utilized and deemed necessary to count toward staffing ratios.

25 Within 120 days of the effective date of this amendatory
26 Act of the 97th General Assembly, the Department shall

1 promulgate rules specific to the staffing requirements for
2 facilities licensed under the Specialized Mental Health
3 Rehabilitation Act. These rules shall recognize the unique
4 nature of individuals with chronic mental health conditions,
5 shall include minimum requirements for specialized clinical
6 staff, including clinical social workers, psychiatrists,
7 psychologists, and direct care staff set forth in paragraphs
8 (4) through (6) and any other specialized staff which may be
9 utilized and deemed necessary to count toward staffing ratios.

10 (b) Beginning January 1, 2011, and thereafter, light
11 intermediate care shall be staffed at the same staffing ratio
12 as intermediate care.

13 (c) Facilities shall notify the Department within 60 days
14 after the effective date of this amendatory Act of the 96th
15 General Assembly, in a form and manner prescribed by the
16 Department, of the staffing ratios in effect on the effective
17 date of this amendatory Act of the 96th General Assembly for
18 both intermediate and skilled care and the number of residents
19 receiving each level of care.

20 (d) (1) Effective July 1, 2010, for each resident needing
21 skilled care, a minimum staffing ratio of 2.5 hours of nursing
22 and personal care each day must be provided; for each resident
23 needing intermediate care, 1.7 hours of nursing and personal
24 care each day must be provided.

25 (2) Effective January 1, 2011, the minimum staffing ratios
26 shall be increased to 2.7 hours of nursing and personal care

1 each day for a resident needing skilled care and 1.9 hours of
2 nursing and personal care each day for a resident needing
3 intermediate care.

4 (3) Effective January 1, 2012, the minimum staffing ratios
5 shall be increased to 3.0 hours of nursing and personal care
6 each day for a resident needing skilled care and 2.1 hours of
7 nursing and personal care each day for a resident needing
8 intermediate care.

9 (4) Effective January 1, 2013, the minimum staffing ratios
10 shall be increased to 3.4 hours of nursing and personal care
11 each day for a resident needing skilled care and 2.3 hours of
12 nursing and personal care each day for a resident needing
13 intermediate care.

14 (5) Effective January 1, 2014, the minimum staffing ratios
15 shall be increased to 3.8 hours of nursing and personal care
16 each day for a resident needing skilled care and 2.5 hours of
17 nursing and personal care each day for a resident needing
18 intermediate care.

19 (e) Ninety days after the effective date of this amendatory
20 Act of the 97th General Assembly, a minimum of 25% of nursing
21 and personal care time shall be provided by licensed nurses,
22 with at least 10% of nursing and personal care time provided by
23 registered nurses. These minimum requirements shall remain in
24 effect until an acuity based registered nurse requirement is
25 promulgated by rule concurrent with the adoption of the
26 Resource Utilization Group classification-based payment

1 methodology, as provided in Section 5-5.2 of the Illinois
2 Public Aid Code. Registered nurses and licensed practical
3 nurses employed by a facility in excess of these requirements
4 may be used to satisfy the remaining 75% of the nursing and
5 personal care time requirements. Notwithstanding this
6 subsection, no staffing requirement in statute in effect on the
7 effective date of this amendatory Act of the 97th General
8 Assembly shall be reduced on account of this subsection.

9 (Source: P.A. 96-1372, eff. 7-29-10; 96-1504, eff. 1-27-11.)

10 Section 50. The Emergency Medical Services (EMS) Systems
11 Act is amended by changing Section 3.86 as follows:

12 (210 ILCS 50/3.86)

13 Sec. 3.86. Stretcher van providers.

14 (a) In this Section, "stretcher van provider" means an
15 entity licensed by the Department to provide non-emergency
16 transportation of passengers on a stretcher in compliance with
17 this Act or the rules adopted by the Department pursuant to
18 this Act, utilizing stretcher vans.

19 (b) The Department has the authority and responsibility to
20 do the following:

21 (1) Require all stretcher van providers, both publicly
22 and privately owned, to be licensed by the Department.

23 (2) Establish licensing and safety standards and
24 requirements for stretcher van providers, through rules

1 adopted pursuant to this Act, including but not limited to:

2 (A) Vehicle design, specification, operation, and
3 maintenance standards.

4 (B) Safety equipment requirements and standards.

5 (C) Staffing requirements.

6 (D) Annual license renewal.

7 (3) License all stretcher van providers that have met
8 the Department's requirements for licensure.

9 (4) Annually inspect all licensed stretcher van
10 providers, and relicense providers that have met the
11 Department's requirements for license renewal.

12 (5) Suspend, revoke, refuse to issue, or refuse to
13 renew the license of any stretcher van provider, or that
14 portion of a license pertaining to a specific vehicle
15 operated by a provider, after an opportunity for a hearing,
16 when findings show that the provider or one or more of its
17 vehicles has failed to comply with the standards and
18 requirements of this Act or the rules adopted by the
19 Department pursuant to this Act.

20 (6) Issue an emergency suspension order for any
21 provider or vehicle licensed under this Act when the
22 Director or his or her designee has determined that an
23 immediate or serious danger to the public health, safety,
24 and welfare exists. Suspension or revocation proceedings
25 that offer an opportunity for a hearing shall be promptly
26 initiated after the emergency suspension order has been

1 issued.

2 (7) Prohibit any stretcher van provider from
3 advertising, identifying its vehicles, or disseminating
4 information in a false or misleading manner concerning the
5 provider's type and level of vehicles, location, response
6 times, level of personnel, licensure status, or EMS System
7 participation.

8 (8) Charge each stretcher van provider a fee, to be
9 submitted with each application for licensure and license
10 renewal.

11 (c) A stretcher van provider may provide transport of a
12 passenger on a stretcher, provided the passenger meets all of
13 the following requirements:

14 (1) (Blank). ~~He or she needs no medical equipment,~~
15 ~~except self-administered medications.~~

16 (2) He or she needs no medical monitoring or clinical
17 observation ~~medical observation~~.

18 (3) He or she needs routine transportation to or from a
19 medical appointment or service if the passenger is
20 convalescent or otherwise bed-confined and does not
21 require clinical observation ~~medical monitoring~~, aid,
22 care, or treatment during transport.

23 (d) A stretcher van provider may not transport a passenger
24 who meets any of the following conditions:

25 (1) He or she is being transported to a hospital for
26 emergency medical treatment. ~~He or she is currently~~

1 ~~admitted to a hospital or is being transported to a~~
2 ~~hospital for admission or emergency treatment.~~

3 (2) He or she has a medical condition that requires
4 active medical monitoring, medical care, medical
5 treatment, or clinical observation during transport by a
6 licensee designated under this Act. ~~He or she is acutely~~
7 ~~ill, wounded, or medically unstable as determined by a~~
8 ~~licensed physician.~~

9 ~~(3) He or she is experiencing an emergency medical~~
10 ~~condition, an acute medical condition, an exacerbation of a~~
11 ~~chronic medical condition, or a sudden illness or injury.~~

12 ~~(4) He or she was administered a medication that might~~
13 ~~prevent the passenger from caring for himself or herself.~~

14 ~~(5) He or she was moved from one environment where~~
15 ~~24 hour medical monitoring or medical observation will~~
16 ~~take place by certified or licensed nursing personnel to~~
17 ~~another such environment. Such environments shall include,~~
18 ~~but not be limited to, hospitals licensed under the~~
19 ~~Hospital Licensing Act or operated under the University of~~
20 ~~Illinois Hospital Act, and nursing facilities licensed~~
21 ~~under the Nursing Home Care Act.~~

22 (c) A stretcher van provider may not transport a passenger
23 who meets any of the following criteria:

24 (1) He or she is being transported to a hospital for
25 emergency medical treatment;

26 (2) He or she is experiencing an emergency medical

1 condition or needs active medical monitoring, including
2 isolation precautions, supplemental oxygen that is not
3 self-administered, continuous airway management,
4 suctioning during transport, or the administration of
5 intravenous fluids during transport.

6 (d) ~~(e)~~ The Stretcher Van Licensure Fund is created as a
7 special fund within the State treasury. All fees received by
8 the Department in connection with the licensure of stretcher
9 van providers under this Section shall be deposited into the
10 fund. Moneys in the fund shall be subject to appropriation to
11 the Department for use in implementing this Section.

12 (Source: P.A. 96-702, eff. 8-25-09; 96-1469, eff. 1-1-11.)

13 Section 53. The Long Term Acute Care Hospital Quality
14 Improvement Transfer Program Act is amended by changing
15 Sections 35, 40, and 45 and by adding Section 55 as follows:

16 (210 ILCS 155/35)

17 Sec. 35. LTAC supplemental per diem rate.

18 (a) The Department must pay an LTAC supplemental per diem
19 rate calculated under this Section to LTAC hospitals that meet
20 the requirements of Section 15 of this Act for patients:

21 (1) who upon admission to the LTAC hospital meet LTAC
22 hospital criteria; and

23 (2) whose care is primarily paid for by the Department
24 under Title XIX of the Social Security Act or whose care is

1 primarily paid for by the Department after the patient has
2 exhausted his or her benefits under Medicare.

3 (b) The Department must not pay the LTAC supplemental per
4 diem rate calculated under this Section if any of the following
5 conditions are met:

6 (1) the LTAC hospital no longer meets the requirements
7 under Section 15 of this Act or terminates the agreement
8 specified under Section 15 of this Act;

9 (2) the patient does not meet the LTAC hospital
10 criteria upon admission; or

11 (3) the patient's care is primarily paid for by
12 Medicare and the patient has not exhausted his or her
13 Medicare benefits, resulting in the Department becoming
14 the primary payer.

15 (c) The Department may adjust the LTAC supplemental per
16 diem rate calculated under this Section based only on the
17 conditions and requirements described under Section 40 and
18 Section 45 of this Act.

19 (d) The LTAC supplemental per diem rate shall be calculated
20 using the LTAC hospital's inflated cost per diem, defined in
21 subsection (f) of this Section, and subtracting the following:

22 (1) The LTAC hospital's Medicaid per diem inpatient
23 rate as calculated under 89 Ill. Adm. Code 148.270(c)(4).

24 (2) The LTAC hospital's disproportionate share (DSH)
25 rate as calculated under 89 Ill. Adm. Code 148.120.

26 (3) The LTAC hospital's Medicaid Percentage Adjustment

1 (MPA) rate as calculated under 89 Ill. Adm. Code 148.122.

2 (4) The LTAC hospital's Medicaid High Volume
3 Adjustment (MHVA) rate as calculated under 89 Ill. Adm.
4 Code 148.290(d).

5 (e) LTAC supplemental per diem rates ~~are~~ effective July 1,
6 2012 shall be the amount in effect as of October 1, 2010. No
7 new hospital may qualify for the program after the effective
8 date of this amendatory Act of the 97th General Assembly for 12
9 months beginning on October 1 of each year and must be updated
10 every 12 months.

11 (f) For the purposes of this Section, "inflated cost per
12 diem" means the quotient resulting from dividing the hospital's
13 inpatient Medicaid costs by the hospital's Medicaid inpatient
14 days and inflating it to the most current period using
15 methodologies consistent with the calculation of the rates
16 described in paragraphs (2), (3), and (4) of subsection (d).
17 The data is obtained from the LTAC hospital's most recent cost
18 report submitted to the Department as mandated under 89 Ill.
19 Adm. Code 148.210.

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

26 (Source: P.A. 96-1130, eff. 7-20-10.)

1 (210 ILCS 155/40)

2 Sec. 40. Rate adjustments for quality measures.

3 (a) The Department may adjust the LTAC supplemental per
4 diem rate calculated under Section 35 of this Act based on the
5 requirements of this Section.

6 (b) After the first year of operation of the Program
7 established by this Act, the Department may reduce the LTAC
8 supplemental per diem rate calculated under Section 35 of this
9 Act by no more than 5% for an LTAC hospital that does not meet
10 benchmarks or targets set by the Department under paragraph (2)
11 of subsection (b) of Section 50.

12 (c) After the first year of operation of the Program
13 established by this Act, the Department may increase the LTAC
14 supplemental per diem rate calculated under Section 35 of this
15 Act by no more than 5% for an LTAC hospital that exceeds the
16 benchmarks or targets set by the Department under paragraph (2)
17 of subsection (a) of Section 50.

18 (d) If an LTAC hospital misses a majority of the benchmarks
19 for quality measures for 3 consecutive years, the Department
20 may reduce the LTAC supplemental per diem rate calculated under
21 Section 35 of this Act to zero.

22 (e) An LTAC hospital whose rate is reduced under subsection
23 (d) of this Section may have the LTAC supplemental per diem
24 rate calculated under Section 35 of this Act reinstated once
25 the LTAC hospital achieves the necessary benchmarks or targets.

1 (f) The Department may apply the reduction described in
2 subsection (d) of this Section after one year instead of 3 to
3 an LTAC hospital that has had its rate previously reduced under
4 subsection (d) of this Section and later has had it reinstated
5 under subsection (e) of this Section.

6 (g) The rate adjustments described in this Section shall be
7 determined and applied only at the beginning of each rate year.

8 (h) On and after July 1, 2012, the Department shall reduce
9 any rate of reimbursement for services or other payments or
10 alter any methodologies authorized by this Act or the Illinois
11 Public Aid Code to reduce any rate of reimbursement for
12 services or other payments in accordance with Section 5-5e of
13 the Illinois Public Aid Code.

14 (Source: P.A. 96-1130, eff. 7-20-10.)

15 (210 ILCS 155/45)

16 Sec. 45. Program evaluation.

17 (a) ~~By After the Program completes the 3rd full year of~~
18 ~~operation on~~ September 30, 2012 ~~2013~~, the Department must
19 complete an evaluation of the Program to determine the actual
20 savings or costs generated by the Program, both on an aggregate
21 basis and on an LTAC hospital-specific basis. ~~The evaluation~~
22 ~~must be conducted in each subsequent year.~~

23 (b) The Department shall consult with ~~and~~ qualified LTAC
24 hospitals to ~~must~~ determine the appropriate methodology to
25 accurately calculate the Program's savings and costs. The

1 calculation shall take into consideration, but shall not be
2 limited to, the length of stay in an acute care hospital prior
3 to transfer, the length of stay in the LTAC taking into account
4 the acuity of the patient at the time of the LTAC admission,
5 and admissions to the LTAC from settings other than an STAC
6 hospital.

7 (c) The evaluation must also determine the effects the
8 Program has had in improving patient satisfaction and health
9 outcomes.

10 (d) If the evaluation indicates that the Program generates
11 a net cost to the Department, the Department may prospectively
12 adjust an individual hospital's LTAC supplemental per diem rate
13 under Section 35 of this Act to establish cost neutrality. The
14 rate adjustments applied under this subsection (d) do not need
15 to be applied uniformly to all qualified LTAC hospitals as long
16 as the adjustments are based on data from the evaluation on
17 hospital-specific information. Cost neutrality under this
18 Section means that the cost to the Department resulting from
19 the LTAC supplemental per diem rate must not exceed the savings
20 generated from transferring the patient from a STAC hospital.

21 (e) The rate adjustment described in subsection (d) of this
22 Section, if necessary, shall be applied to the LTAC
23 supplemental per diem rate for the rate year beginning October
24 1, 2014. The Department may apply this rate adjustment in
25 subsequent rate years if the conditions under subsection (d) of
26 this Section are met. The Department must apply the rate

1 adjustment to an individual LTAC hospital's LTAC supplemental
2 per diem rate only in years when the Program evaluation
3 indicates a net cost for the Department.

4 (f) The Department may establish a shared savings program
5 for qualified LTAC hospitals. ~~The rate adjustments described in~~
6 ~~this Section shall be determined and applied only at the~~
7 ~~beginning of each rate year.~~

8 (Source: P.A. 96-1130, eff. 7-20-10.)

9 (210 ILCS 155/55 new)

10 Sec. 55. Demonstration care coordination program for
11 post-acute care.

12 (a) The Department may develop a demonstration care
13 coordination program for LTAC hospital appropriate patients
14 with the goal of improving the continuum of care for patients
15 who have been discharged from an LTAC hospital.

16 (b) The program shall require risk-sharing and quality
17 targets.

18 Section 65. The Children's Health Insurance Program Act is
19 amended by changing Sections 25 and 40 as follows:

20 (215 ILCS 106/25)

21 Sec. 25. Health benefits for children.

22 (a) The Department shall, subject to appropriation,
23 provide health benefits coverage to eligible children by:

1 (1) Subsidizing the cost of privately sponsored health
2 insurance, including employer based health insurance, to
3 assist families to take advantage of available privately
4 sponsored health insurance for their eligible children;
5 and

6 (2) Purchasing or providing health care benefits for
7 eligible children. The health benefits provided under this
8 subdivision (a)(2) shall, subject to appropriation and
9 without regard to any applicable cost sharing under Section
10 30, be identical to the benefits provided for children
11 under the State's approved plan under Title XIX of the
12 Social Security Act. Providers under this subdivision
13 (a)(2) shall be subject to approval by the Department to
14 provide health care under the Illinois Public Aid Code and
15 shall be reimbursed at the same rate as providers under the
16 State's approved plan under Title XIX of the Social
17 Security Act. In addition, providers may retain
18 co-payments when determined appropriate by the Department.

19 (b) The subsidization provided pursuant to subdivision
20 (a)(1) shall be credited to the family of the eligible child.

21 (c) The Department is prohibited from denying coverage to a
22 child who is enrolled in a privately sponsored health insurance
23 plan pursuant to subdivision (a)(1) because the plan does not
24 meet federal benchmarking standards or cost sharing and
25 contribution requirements. To be eligible for inclusion in the
26 Program, the plan shall contain comprehensive major medical

1 coverage which shall consist of physician and hospital
2 inpatient services. The Department is prohibited from denying
3 coverage to a child who is enrolled in a privately sponsored
4 health insurance plan pursuant to subdivision (a)(1) because
5 the plan offers benefits in addition to physician and hospital
6 inpatient services.

7 (d) The total dollar amount of subsidizing coverage per
8 child per month pursuant to subdivision (a)(1) shall be equal
9 to the average dollar payments, less premiums incurred, per
10 child per month pursuant to subdivision (a)(2). The Department
11 shall set this amount prospectively based upon the prior fiscal
12 year's experience adjusted for incurred but not reported claims
13 and estimated increases or decreases in the cost of medical
14 care. Payments obligated before July 1, 1999, will be computed
15 using State Fiscal Year 1996 payments for children eligible for
16 Medical Assistance and income assistance under the Aid to
17 Families with Dependent Children Program, with appropriate
18 adjustments for cost and utilization changes through January 1,
19 1999. The Department is prohibited from providing a subsidy
20 pursuant to subdivision (a)(1) that is more than the
21 individual's monthly portion of the premium.

22 (e) An eligible child may obtain immediate coverage under
23 this Program only once during a medical visit. If coverage
24 lapses, re-enrollment shall be completed in advance of the next
25 covered medical visit and the first month's required premium
26 shall be paid in advance of any covered medical visit.

1 (f) In order to accelerate and facilitate the development
2 of networks to deliver services to children in areas outside
3 counties with populations in excess of 3,000,000, in the event
4 less than 25% of the eligible children in a county or
5 contiguous counties has enrolled with a Health Maintenance
6 Organization pursuant to Section 5-11 of the Illinois Public
7 Aid Code, the Department may develop and implement
8 demonstration projects to create alternative networks designed
9 to enhance enrollment and participation in the program. The
10 Department shall prescribe by rule the criteria, standards, and
11 procedures for effecting demonstration projects under this
12 Section.

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

19 (Source: P.A. 90-736, eff. 8-12-98.)

20 (215 ILCS 106/40)

21 Sec. 40. Waivers. ~~(a)~~ The Department shall request any
22 necessary waivers of federal requirements in order to allow
23 receipt of federal funding. ~~for:~~

24 ~~(1) the coverage of families with eligible children~~
25 ~~under this Act; and~~

1 ~~(2) the coverage of children who would otherwise be~~
2 ~~eligible under this Act, but who have health insurance.~~

3 ~~(b) The failure of the responsible federal agency to~~
4 ~~approve a waiver for children who would otherwise be eligible~~
5 ~~under this Act but who have health insurance shall not prevent~~
6 ~~the implementation of any Section of this Act provided that~~
7 ~~there are sufficient appropriated funds.~~

8 ~~(c) Eligibility of a person under an approved waiver due to~~
9 ~~the relationship with a child pursuant to Article V of the~~
10 ~~Illinois Public Aid Code or this Act shall be limited to such a~~
11 ~~person whose countable income is determined by the Department~~
12 ~~to be at or below such income eligibility standard as the~~
13 ~~Department by rule shall establish. The income level~~
14 ~~established by the Department shall not be below 90% of the~~
15 ~~federal poverty level. Such persons who are determined to be~~
16 ~~eligible must reapply, or otherwise establish eligibility, at~~
17 ~~least annually. An eligible person shall be required, as~~
18 ~~determined by the Department by rule, to report promptly those~~
19 ~~changes in income and other circumstances that affect~~
20 ~~eligibility. The eligibility of a person may be redetermined~~
21 ~~based on the information reported or may be terminated based on~~
22 ~~the failure to report or failure to report accurately. A person~~
23 ~~may also be held liable to the Department for any payments made~~
24 ~~by the Department on such person's behalf that were~~
25 ~~inappropriate. An applicant shall be provided with notice of~~
26 ~~these obligations.~~

1 (Source: P.A. 96-328, eff. 8-11-09.)

2 Section 70. The Covering ALL KIDS Health Insurance Act is
3 amended by changing Sections 30 and 35 as follows:

4 (215 ILCS 170/30)

5 (Section scheduled to be repealed on July 1, 2016)

6 Sec. 30. Program outreach and marketing. The Department may
7 provide grants to application agents and other community-based
8 organizations to educate the public about the availability of
9 the Program. The Department shall adopt rules regarding
10 performance standards and outcomes measures expected of
11 organizations that are awarded grants under this Section,
12 including penalties for nonperformance of contract standards.

13 The Department shall annually publish electronically on a
14 State website ~~and in no less than 2 newspapers in the State~~ the
15 premiums or other cost sharing requirements of the Program.

16 (Source: P.A. 94-693, eff. 7-1-06; 95-985, eff. 6-1-09.)

17 (215 ILCS 170/35)

18 (Section scheduled to be repealed on July 1, 2016)

19 Sec. 35. Health care benefits for children.

20 (a) The Department shall purchase or provide health care
21 benefits for eligible children that are identical to the
22 benefits provided for children under the Illinois Children's
23 Health Insurance Program Act, except for non-emergency

1 transportation.

2 (b) As an alternative to the benefits set forth in
3 subsection (a), and when cost-effective, the Department may
4 offer families subsidies toward the cost of privately sponsored
5 health insurance, including employer-sponsored health
6 insurance.

7 (c) Notwithstanding clause (i) of subdivision (a)(3) of
8 Section 20, the Department may consider offering, as an
9 alternative to the benefits set forth in subsection (a),
10 partial coverage to children who are enrolled in a
11 high-deductible private health insurance plan.

12 (d) Notwithstanding clause (i) of subdivision (a)(3) of
13 Section 20, the Department may consider offering, as an
14 alternative to the benefits set forth in subsection (a), a
15 limited package of benefits to children in families who have
16 private or employer-sponsored health insurance that does not
17 cover certain benefits such as dental or vision benefits.

18 (e) The content and availability of benefits described in
19 subsections (b), (c), and (d), and the terms of eligibility for
20 those benefits, shall be at the Department's discretion and the
21 Department's determination of efficacy and cost-effectiveness
22 as a means of promoting retention of private or
23 employer-sponsored health insurance.

24 (f) On and after July 1, 2012, the Department shall reduce
25 any rate of reimbursement for services or other payments or
26 alter any methodologies authorized by this Act or the Illinois

1 Public Aid Code to reduce any rate of reimbursement for
2 services or other payments in accordance with Section 5-5e of
3 the Illinois Public Aid Code.

4 (Source: P.A. 94-693, eff. 7-1-06.)

5 Section 75. The Illinois Public Aid Code is amended by
6 changing Sections 3-1.2, 5-1.4, 5-2, 5-2.03, 5-4, 5-4.1, 5-4.2,
7 5-5, 5-5.02, 5-5.05, 5-5.2, 5-5.3, 5-5.4, 5-5.4e, 5-5.5,
8 5-5.8b, 5-5.12, 5-5.17, 5-5.20, 5-5.23, 5-5.24, 5-5.25,
9 5-16.7, 5-16.7a, 5-16.8, 5-16.9, 5-17, 5-19, 5-24, 5-30, 5A-1,
10 5A-2, 5A-3, 5A-4, 5A-5, 5A-6, 5A-8, 5A-10, 5A-12.2, 5A-14,
11 6-11, 11-13, 11-26, 12-4.25, 12-4.38, 12-4.39, 12-10.5,
12 12-13.1, 14-8, 15-1, 15-2, 15-5, and 15-11 and by adding
13 Sections 5-2b, 5-2.1d, 5-5e, 5-5e.1, 5-5f, 5A-15, 11-5.2,
14 11-5.3, and 14-11 as follows:

15 (305 ILCS 5/3-1.2) (from Ch. 23, par. 3-1.2)

16 Sec. 3-1.2. Need. Income available to the person, when
17 added to contributions in money, substance, or services from
18 other sources, including contributions from legally
19 responsible relatives, must be insufficient to equal the grant
20 amount established by Department regulation for such person.

21 In determining earned income to be taken into account,
22 consideration shall be given to any expenses reasonably
23 attributable to the earning of such income. If federal law or
24 regulations permit or require exemption of earned or other

1 income and resources, the Illinois Department shall provide by
2 rule and regulation that the amount of income to be disregarded
3 be increased (1) to the maximum extent so required and (2) to
4 the maximum extent permitted by federal law or regulation in
5 effect as of the date this Amendatory Act becomes law. The
6 Illinois Department may also provide by rule and regulation
7 that the amount of resources to be disregarded be increased to
8 the maximum extent so permitted or required. Subject to federal
9 approval, resources (for example, land, buildings, equipment,
10 supplies, or tools), including farmland property and personal
11 property used in the income-producing operations related to the
12 farmland (for example, equipment and supplies, motor vehicles,
13 or tools), necessary for self-support, up to \$6,000 of the
14 person's equity in the income-producing property, provided
15 that the property produces a net annual income of at least 6%
16 of the excluded equity value of the property, are exempt.
17 Equity value in excess of \$6,000 shall not be excluded if the
18 activity produces income that is less than 6% of the exempt
19 equity due to reasons beyond the person's control (for example,
20 the person's illness or crop failure) and there is a reasonable
21 expectation that the property will again produce income equal
22 to or greater than 6% of the equity value (for example, a
23 medical prognosis that the person is expected to respond to
24 treatment or that drought-resistant corn will be planted). If
25 the person owns more than one piece of property and each
26 produces income, each piece of property shall be looked at to

1 determine whether the 6% rule is met, and then the amounts of
2 the person's equity in all of those properties shall be totaled
3 to determine whether the total equity is \$6,000 or less. The
4 total equity value of all properties that is exempt shall be
5 limited to \$6,000.

6 In determining the resources of an individual or any
7 dependents, the Department shall exclude from consideration
8 the value of funeral and burial spaces, ~~grave markers and other~~
9 ~~funeral and burial merchandise,~~ funeral and burial insurance
10 the proceeds of which can only be used to pay the funeral and
11 burial expenses of the insured and funds specifically set aside
12 for the funeral and burial arrangements of the individual or
13 his or her dependents, including prepaid funeral and burial
14 plans, to the same extent that such items are excluded from
15 consideration under the federal Supplemental Security Income
16 program (SSI).

17 Prepaid funeral or burial contracts are exempt to the
18 following extent:

19 (1) Funds in a revocable prepaid funeral or burial
20 contract are exempt up to \$1,500, except that any portion
21 of a contract that clearly represents the purchase of
22 burial space, as that term is defined for purposes of the
23 Supplemental Security Income program, is exempt regardless
24 of value.

25 (2) Funds in an irrevocable prepaid funeral or burial
26 contract are exempt up to \$5,874, except that any portion

1 of a contract that clearly represents the purchase of
2 burial space, as that term is defined for purposes of the
3 Supplemental Security Income program, is exempt regardless
4 of value. This amount shall be adjusted annually for any
5 increase in the Consumer Price Index. The amount exempted
6 shall be limited to the price of the funeral goods and
7 services to be provided upon death. The contract must
8 provide a complete description of the funeral goods and
9 services to be provided and the price thereof. Any amount
10 in the contract not so specified shall be treated as a
11 transfer of assets for less than fair market value.

12 (3) A prepaid, guaranteed-price funeral or burial
13 contract, funded by an irrevocable assignment of a person's
14 life insurance policy to a trust, is exempt. The amount
15 exempted shall be limited to the amount of the insurance
16 benefit designated for the cost of the funeral goods and
17 services to be provided upon the person's death. The
18 contract must provide a complete description of the funeral
19 goods and services to be provided and the price thereof.
20 Any amount in the contract not so specified shall be
21 treated as a transfer of assets for less than fair market
22 value. The trust must include a statement that, upon the
23 death of the person, the State will receive all amounts
24 remaining in the trust, including any remaining payable
25 proceeds under the insurance policy up to an amount equal
26 to the total medical assistance paid on behalf of the

1 person. The trust is responsible for ensuring that the
2 provider of funeral services under the contract receives
3 the proceeds of the policy when it provides the funeral
4 goods and services specified under the contract. The
5 irrevocable assignment of ownership of the insurance
6 policy must be acknowledged by the insurance company.

7 Notwithstanding any other provision of this Code to the
8 contrary, an irrevocable trust containing the resources of a
9 person who is determined to have a disability shall be
10 considered exempt from consideration. Such trust must be
11 established and managed by a non-profit association that pools
12 funds but maintains a separate account for each beneficiary.
13 The trust may be established by the person, a parent,
14 grandparent, legal guardian, or court. It must be established
15 for the sole benefit of the person and language contained in
16 the trust shall stipulate that any amount remaining in the
17 trust (up to the amount expended by the Department on medical
18 assistance) that is not retained by the trust for reasonable
19 administrative costs related to wrapping up the affairs of the
20 subaccount shall be paid to the Department upon the death of
21 the person. After a person reaches age 65, any funding by or on
22 behalf of the person to the trust shall be treated as a
23 transfer of assets for less than fair market value unless the
24 person is a ward of a county public guardian or the State
25 guardian pursuant to Section 13-5 of the Probate Act of 1975 or
26 Section 30 of the Guardianship and Advocacy Act and lives in

1 the community, or the person is a ward of a county public
2 guardian or the State guardian pursuant to Section 13-5 of the
3 Probate Act of 1975 or Section 30 of the Guardianship and
4 Advocacy Act and a court has found that any expenditures from
5 the trust will maintain or enhance the person's quality of
6 life. If the trust contains proceeds from a personal injury
7 settlement, any Department charge must be satisfied in order
8 for the transfer to the trust to be treated as a transfer for
9 fair market value.

10 The homestead shall be exempt from consideration except to
11 the extent that it meets the income and shelter needs of the
12 person. "Homestead" means the dwelling house and contiguous
13 real estate owned and occupied by the person, regardless of its
14 value. Subject to federal approval, a person shall not be
15 eligible for long-term care services, however, if the person's
16 equity interest in his or her homestead exceeds the minimum
17 home equity as allowed and increased annually under federal
18 law. Subject to federal approval, on and after the effective
19 date of this amendatory Act of the 97th General Assembly,
20 homestead property transferred to a trust shall no longer be
21 considered homestead property.

22 Occasional or irregular gifts in cash, goods or services
23 from persons who are not legally responsible relatives which
24 are of nominal value or which do not have significant effect in
25 meeting essential requirements shall be disregarded. The
26 eligibility of any applicant for or recipient of public aid

1 under this Article is not affected by the payment of any grant
2 under the "Senior Citizens and Disabled Persons Property Tax
3 Relief ~~and Pharmaceutical Assistance Act~~" or any distributions
4 or items of income described under subparagraph (X) of
5 paragraph (2) of subsection (a) of Section 203 of the Illinois
6 Income Tax Act.

7 The Illinois Department may, after appropriate
8 investigation, establish and implement a consolidated standard
9 to determine need and eligibility for and amount of benefits
10 under this Article or a uniform cash supplement to the federal
11 Supplemental Security Income program for all or any part of the
12 then current recipients under this Article; provided, however,
13 that the establishment or implementation of such a standard or
14 supplement shall not result in reductions in benefits under
15 this Article for the then current recipients of such benefits.

16 (Source: P.A. 91-676, eff. 12-23-99.)

17 (305 ILCS 5/5-1.4)

18 Sec. 5-1.4. Moratorium on eligibility expansions.
19 Beginning on the effective date of this amendatory Act of the
20 96th General Assembly, there shall be a 2-year moratorium on
21 the expansion of eligibility through increasing financial
22 eligibility standards, or through increasing income
23 disregards, or through the creation of new programs which would
24 add new categories of eligible individuals under the medical
25 assistance program in addition to those categories covered on

1 January 1, 2011. This moratorium shall not apply to expansions
2 required as a federal condition of State participation in the
3 medical assistance program or to expansions approved by the
4 federal government that are financed entirely by units of local
5 government and federal matching funds. If the State of Illinois
6 finds that the State has borne a cost related to such an
7 expansion, the unit of local government shall reimburse the
8 State. All federal funds associated with an expansion funded by
9 a unit of local government shall be returned to the unit of
10 local government funding the expansion, pursuant to an
11 intergovernmental agreement between the Department of
12 Healthcare and Family Services and the unit of local
13 government. Within 10 calendar days of the effective date of
14 this amendatory Act of the 97th General Assembly, the
15 Department of Healthcare and Family Services shall formally
16 advise the Centers for Medicare and Medicaid Services of the
17 passage of this amendatory Act of the 97th General Assembly.
18 The State is prohibited from submitting additional waiver
19 requests that expand or allow for an increase in the classes of
20 persons eligible for medical assistance under this Article to
21 the federal government for its consideration beginning on the
22 20th calendar day following the effective date of this
23 amendatory Act of the 97th General Assembly until January 25,
24 2013.

25 (Source: P.A. 96-1501, eff. 1-25-11.)

1 (305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

2 Sec. 5-2. Classes of Persons Eligible. Medical assistance
3 under this Article shall be available to any of the following
4 classes of persons in respect to whom a plan for coverage has
5 been submitted to the Governor by the Illinois Department and
6 approved by him:

7 1. Recipients of basic maintenance grants under
8 Articles III and IV.

9 2. Persons otherwise eligible for basic maintenance
10 under Articles III and IV, excluding any eligibility
11 requirements that are inconsistent with any federal law or
12 federal regulation, as interpreted by the U.S. Department
13 of Health and Human Services, but who fail to qualify
14 thereunder on the basis of need or who qualify but are not
15 receiving basic maintenance under Article IV, and who have
16 insufficient income and resources to meet the costs of
17 necessary medical care, including but not limited to the
18 following:

19 (a) All persons otherwise eligible for basic
20 maintenance under Article III but who fail to qualify
21 under that Article on the basis of need and who meet
22 either of the following requirements:

23 (i) their income, as determined by the
24 Illinois Department in accordance with any federal
25 requirements, is equal to or less than 70% in
26 fiscal year 2001, equal to or less than 85% in

1 fiscal year 2002 and until a date to be determined
2 by the Department by rule, and equal to or less
3 than 100% beginning on the date determined by the
4 Department by rule, of the nonfarm income official
5 poverty line, as defined by the federal Office of
6 Management and Budget and revised annually in
7 accordance with Section 673(2) of the Omnibus
8 Budget Reconciliation Act of 1981, applicable to
9 families of the same size; or

10 (ii) their income, after the deduction of
11 costs incurred for medical care and for other types
12 of remedial care, is equal to or less than 70% in
13 fiscal year 2001, equal to or less than 85% in
14 fiscal year 2002 and until a date to be determined
15 by the Department by rule, and equal to or less
16 than 100% beginning on the date determined by the
17 Department by rule, of the nonfarm income official
18 poverty line, as defined in item (i) of this
19 subparagraph (a).

20 (b) All persons who, excluding any eligibility
21 requirements that are inconsistent with any federal
22 law or federal regulation, as interpreted by the U.S.
23 Department of Health and Human Services, would be
24 determined eligible for such basic maintenance under
25 Article IV by disregarding the maximum earned income
26 permitted by federal law.

1 3. Persons who would otherwise qualify for Aid to the
2 Medically Indigent under Article VII.

3 4. Persons not eligible under any of the preceding
4 paragraphs who fall sick, are injured, or die, not having
5 sufficient money, property or other resources to meet the
6 costs of necessary medical care or funeral and burial
7 expenses.

8 5.(a) Women during pregnancy, after the fact of
9 pregnancy has been determined by medical diagnosis, and
10 during the 60-day period beginning on the last day of the
11 pregnancy, together with their infants and children born
12 after September 30, 1983, whose income and resources are
13 insufficient to meet the costs of necessary medical care to
14 the maximum extent possible under Title XIX of the Federal
15 Social Security Act.

16 (b) The Illinois Department and the Governor shall
17 provide a plan for coverage of the persons eligible under
18 paragraph 5(a) by April 1, 1990. Such plan shall provide
19 ambulatory prenatal care to pregnant women during a
20 presumptive eligibility period and establish an income
21 eligibility standard that is equal to 133% of the nonfarm
22 income official poverty line, as defined by the federal
23 Office of Management and Budget and revised annually in
24 accordance with Section 673(2) of the Omnibus Budget
25 Reconciliation Act of 1981, applicable to families of the
26 same size, provided that costs incurred for medical care

1 are not taken into account in determining such income
2 eligibility.

3 (c) The Illinois Department may conduct a
4 demonstration in at least one county that will provide
5 medical assistance to pregnant women, together with their
6 infants and children up to one year of age, where the
7 income eligibility standard is set up to 185% of the
8 nonfarm income official poverty line, as defined by the
9 federal Office of Management and Budget. The Illinois
10 Department shall seek and obtain necessary authorization
11 provided under federal law to implement such a
12 demonstration. Such demonstration may establish resource
13 standards that are not more restrictive than those
14 established under Article IV of this Code.

15 6. Persons under the age of 18 who fail to qualify as
16 dependent under Article IV and who have insufficient income
17 and resources to meet the costs of necessary medical care
18 to the maximum extent permitted under Title XIX of the
19 Federal Social Security Act.

20 7. (Blank). ~~Persons who are under 21 years of age and~~
21 ~~would qualify as disabled as defined under the Federal~~
22 ~~Supplemental Security Income Program, provided medical~~
23 ~~service for such persons would be eligible for Federal~~
24 ~~Financial Participation, and provided the Illinois~~
25 ~~Department determines that:~~

26 ~~(a) the person requires a level of care provided by~~

1 ~~a hospital, skilled nursing facility, or intermediate~~
2 ~~care facility, as determined by a physician licensed to~~
3 ~~practice medicine in all its branches;~~

4 ~~(b) it is appropriate to provide such care outside~~
5 ~~of an institution, as determined by a physician~~
6 ~~licensed to practice medicine in all its branches;~~

7 ~~(c) the estimated amount which would be expended~~
8 ~~for care outside the institution is not greater than~~
9 ~~the estimated amount which would be expended in an~~
10 ~~institution.~~

11 8. Persons who become ineligible for basic maintenance
12 assistance under Article IV of this Code in programs
13 administered by the Illinois Department due to employment
14 earnings and persons in assistance units comprised of
15 adults and children who become ineligible for basic
16 maintenance assistance under Article VI of this Code due to
17 employment earnings. The plan for coverage for this class
18 of persons shall:

19 (a) extend the medical assistance coverage for up
20 to 12 months following termination of basic
21 maintenance assistance; and

22 (b) offer persons who have initially received 6
23 months of the coverage provided in paragraph (a) above,
24 the option of receiving an additional 6 months of
25 coverage, subject to the following:

26 (i) such coverage shall be pursuant to

1 provisions of the federal Social Security Act;

2 (ii) such coverage shall include all services
3 covered while the person was eligible for basic
4 maintenance assistance;

5 (iii) no premium shall be charged for such
6 coverage; and

7 (iv) such coverage shall be suspended in the
8 event of a person's failure without good cause to
9 file in a timely fashion reports required for this
10 coverage under the Social Security Act and
11 coverage shall be reinstated upon the filing of
12 such reports if the person remains otherwise
13 eligible.

14 9. Persons with acquired immunodeficiency syndrome
15 (AIDS) or with AIDS-related conditions with respect to whom
16 there has been a determination that but for home or
17 community-based services such individuals would require
18 the level of care provided in an inpatient hospital,
19 skilled nursing facility or intermediate care facility the
20 cost of which is reimbursed under this Article. Assistance
21 shall be provided to such persons to the maximum extent
22 permitted under Title XIX of the Federal Social Security
23 Act.

24 10. Participants in the long-term care insurance
25 partnership program established under the Illinois
26 Long-Term Care Partnership Program Act who meet the

1 qualifications for protection of resources described in
2 Section 15 of that Act.

3 11. Persons with disabilities who are employed and
4 eligible for Medicaid, pursuant to Section
5 1902(a)(10)(A)(ii)(xv) of the Social Security Act, and,
6 subject to federal approval, persons with a medically
7 improved disability who are employed and eligible for
8 Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of
9 the Social Security Act, as provided by the Illinois
10 Department by rule. In establishing eligibility standards
11 under this paragraph 11, the Department shall, subject to
12 federal approval:

13 (a) set the income eligibility standard at not
14 lower than 350% of the federal poverty level;

15 (b) exempt retirement accounts that the person
16 cannot access without penalty before the age of 59 1/2,
17 and medical savings accounts established pursuant to
18 26 U.S.C. 220;

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

22 (d) continue to apply subparagraphs (b) and (c) in
23 determining the eligibility of the person under this
24 Article even if the person loses eligibility under this
25 paragraph 11.

26 12. Subject to federal approval, persons who are

1 eligible for medical assistance coverage under applicable
2 provisions of the federal Social Security Act and the
3 federal Breast and Cervical Cancer Prevention and
4 Treatment Act of 2000. Those eligible persons are defined
5 to include, but not be limited to, the following persons:

6 (1) persons who have been screened for breast or
7 cervical cancer under the U.S. Centers for Disease
8 Control and Prevention Breast and Cervical Cancer
9 Program established under Title XV of the federal
10 Public Health Services Act in accordance with the
11 requirements of Section 1504 of that Act as
12 administered by the Illinois Department of Public
13 Health; and

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

18 "Medical assistance" under this paragraph 12 shall be
19 identical to the benefits provided under the State's
20 approved plan under Title XIX of the Social Security Act.
21 The Department must request federal approval of the
22 coverage under this paragraph 12 within 30 days after the
23 effective date of this amendatory Act of the 92nd General
24 Assembly.

25 In addition to the persons who are eligible for medical
26 assistance pursuant to subparagraphs (1) and (2) of this

1 paragraph 12, and to be paid from funds appropriated to the
2 Department for its medical programs, any uninsured person
3 as defined by the Department in rules residing in Illinois
4 who is younger than 65 years of age, who has been screened
5 for breast and cervical cancer in accordance with standards
6 and procedures adopted by the Department of Public Health
7 for screening, and who is referred to the Department by the
8 Department of Public Health as being in need of treatment
9 for breast or cervical cancer is eligible for medical
10 assistance benefits that are consistent with the benefits
11 provided to those persons described in subparagraphs (1)
12 and (2). Medical assistance coverage for the persons who
13 are eligible under the preceding sentence is not dependent
14 on federal approval, but federal moneys may be used to pay
15 for services provided under that coverage upon federal
16 approval.

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

22 14. Subject to the availability of funds for this
23 purpose, the Department may provide coverage under this
24 Article to persons who reside in Illinois who are not
25 eligible under any of the preceding paragraphs and who meet
26 the income guidelines of paragraph 2(a) of this Section and

1 (i) have an application for asylum pending before the
2 federal Department of Homeland Security or on appeal before
3 a court of competent jurisdiction and are represented
4 either by counsel or by an advocate accredited by the
5 federal Department of Homeland Security and employed by a
6 not-for-profit organization in regard to that application
7 or appeal, or (ii) are receiving services through a
8 federally funded torture treatment center. Medical
9 coverage under this paragraph 14 may be provided for up to
10 24 continuous months from the initial eligibility date so
11 long as an individual continues to satisfy the criteria of
12 this paragraph 14. If an individual has an appeal pending
13 regarding an application for asylum before the Department
14 of Homeland Security, eligibility under this paragraph 14
15 may be extended until a final decision is rendered on the
16 appeal. The Department may adopt rules governing the
17 implementation of this paragraph 14.

18 15. Family Care Eligibility.

19 (a) On and after July 1, 2012 ~~Through December 31,~~
20 ~~2013,~~ a caretaker relative who is 19 years of age or
21 older when countable income is at or below 133% ~~185%~~ of
22 the Federal Poverty Level Guidelines, as published
23 annually in the Federal Register, for the appropriate
24 family size. ~~Beginning January 1, 2014, a caretaker~~
25 ~~relative who is 19 years of age or older when countable~~
26 ~~income is at or below 133% of the Federal Poverty Level~~

1 ~~Guidelines, as published annually in the Federal~~
2 ~~Register, for the appropriate family size.~~ A person may
3 not spend down to become eligible under this paragraph
4 15.

5 (b) Eligibility shall be reviewed annually.

6 (c) (Blank). ~~Caretaker relatives enrolled under~~
7 ~~this paragraph 15 in families with countable income~~
8 ~~above 150% and at or below 185% of the Federal Poverty~~
9 ~~Level Guidelines shall be counted as family members and~~
10 ~~pay premiums as established under the Children's~~
11 ~~Health Insurance Program Act.~~

12 (d) (Blank). ~~Premiums shall be billed by and~~
13 ~~payable to the Department or its authorized agent, on a~~
14 ~~monthly basis.~~

15 (e) (Blank). ~~The premium due date is the last day~~
16 ~~of the month preceding the month of coverage.~~

17 (f) (Blank). ~~Individuals shall have a grace period~~
18 ~~through 60 days of coverage to pay the premium.~~

19 (g) (Blank). ~~Failure to pay the full monthly~~
20 ~~premium by the last day of the grace period shall~~
21 ~~result in termination of coverage.~~

22 (h) (Blank). ~~Partial premium payments shall not be~~
23 ~~refunded.~~

24 (i) Following termination of an individual's
25 coverage under this paragraph 15, the individual must
26 be determined eligible before the person can be

1 ~~re-enrolled. following action is required before the~~
2 ~~individual can be re-enrolled:~~

3 ~~(1) A new application must be completed and the~~
4 ~~individual must be determined otherwise eligible.~~

5 ~~(2) There must be full payment of premiums due~~
6 ~~under this Code, the Children's Health Insurance~~
7 ~~Program Act, the Covering ALL KIDS Health~~
8 ~~Insurance Act, or any other healthcare program~~
9 ~~administered by the Department for periods in~~
10 ~~which a premium was owed and not paid for the~~
11 ~~individual.~~

12 ~~(3) The first month's premium must be paid if~~
13 ~~there was an unpaid premium on the date the~~
14 ~~individual's previous coverage was canceled.~~

15 ~~The Department is authorized to implement the~~
16 ~~provisions of this amendatory Act of the 95th General~~
17 ~~Assembly by adopting the medical assistance rules in effect~~
18 ~~as of October 1, 2007, at 89 Ill. Admin. Code 125, and at~~
19 ~~89 Ill. Admin. Code 120.32 along with only those changes~~
20 ~~necessary to conform to federal Medicaid requirements,~~
21 ~~federal laws, and federal regulations, including but not~~
22 ~~limited to Section 1931 of the Social Security Act (42~~
23 ~~U.S.C. Sec. 1396u-1), as interpreted by the U.S. Department~~
24 ~~of Health and Human Services, and the countable income~~
25 ~~eligibility standard authorized by this paragraph 15. The~~
26 ~~Department may not otherwise adopt any rule to implement~~

1 ~~this increase except as authorized by law, to meet the~~
2 ~~eligibility standards authorized by the federal government~~
3 ~~in the Medicaid State Plan or the Title XXI Plan, or to~~
4 ~~meet an order from the federal government or any court.~~

5 16. Subject to appropriation, uninsured persons who
6 are not otherwise eligible under this Section who have been
7 certified and referred by the Department of Public Health
8 as having been screened and found to need diagnostic
9 evaluation or treatment, or both diagnostic evaluation and
10 treatment, for prostate or testicular cancer. For the
11 purposes of this paragraph 16, uninsured persons are those
12 who do not have creditable coverage, as defined under the
13 Health Insurance Portability and Accountability Act, or
14 have otherwise exhausted any insurance benefits they may
15 have had, for prostate or testicular cancer diagnostic
16 evaluation or treatment, or both diagnostic evaluation and
17 treatment. To be eligible, a person must furnish a Social
18 Security number. A person's assets are exempt from
19 consideration in determining eligibility under this
20 paragraph 16. Such persons shall be eligible for medical
21 assistance under this paragraph 16 for so long as they need
22 treatment for the cancer. A person shall be considered to
23 need treatment if, in the opinion of the person's treating
24 physician, the person requires therapy directed toward
25 cure or palliation of prostate or testicular cancer,
26 including recurrent metastatic cancer that is a known or

1 presumed complication of prostate or testicular cancer and
2 complications resulting from the treatment modalities
3 themselves. Persons who require only routine monitoring
4 services are not considered to need treatment. "Medical
5 assistance" under this paragraph 16 shall be identical to
6 the benefits provided under the State's approved plan under
7 Title XIX of the Social Security Act. Notwithstanding any
8 other provision of law, the Department (i) does not have a
9 claim against the estate of a deceased recipient of
10 services under this paragraph 16 and (ii) does not have a
11 lien against any homestead property or other legal or
12 equitable real property interest owned by a recipient of
13 services under this paragraph 16.

14 17. Persons who, pursuant to a waiver approved by the
15 Secretary of the U.S. Department of Health and Human
16 Services, are eligible for medical assistance under Title
17 XIX or XXI of the federal Social Security Act.
18 Notwithstanding any other provision of this Code and
19 consistent with the terms of the approved waiver, the
20 Illinois Department, may by rule:

21 (a) Limit the geographic areas in which the waiver
22 program operates.

23 (b) Determine the scope, quantity, duration, and
24 quality, and the rate and method of reimbursement, of
25 the medical services to be provided, which may differ
26 from those for other classes of persons eligible for

1 assistance under this Article.

2 (c) Restrict the persons' freedom in choice of
3 providers.

4 In implementing the provisions of Public Act 96-20, the
5 Department is authorized to adopt only those rules necessary,
6 including emergency rules. Nothing in Public Act 96-20 permits
7 the Department to adopt rules or issue a decision that expands
8 eligibility for the FamilyCare Program to a person whose income
9 exceeds 185% of the Federal Poverty Level as determined from
10 time to time by the U.S. Department of Health and Human
11 Services, unless the Department is provided with express
12 statutory authority.

13 The Illinois Department and the Governor shall provide a
14 plan for coverage of the persons eligible under paragraph 7 as
15 soon as possible after July 1, 1984.

16 The eligibility of any such person for medical assistance
17 under this Article is not affected by the payment of any grant
18 under the Senior Citizens and Disabled Persons Property Tax
19 Relief ~~and Pharmaceutical Assistance~~ Act or any distributions
20 or items of income described under subparagraph (X) of
21 paragraph (2) of subsection (a) of Section 203 of the Illinois
22 Income Tax Act. The Department shall by rule establish the
23 amounts of assets to be disregarded in determining eligibility
24 for medical assistance, which shall at a minimum equal the
25 amounts to be disregarded under the Federal Supplemental
26 Security Income Program. The amount of assets of a single

1 person to be disregarded shall not be less than \$2,000, and the
2 amount of assets of a married couple to be disregarded shall
3 not be less than \$3,000.

4 To the extent permitted under federal law, any person found
5 guilty of a second violation of Article VIII A shall be
6 ineligible for medical assistance under this Article, as
7 provided in Section 8A-8.

8 The eligibility of any person for medical assistance under
9 this Article shall not be affected by the receipt by the person
10 of donations or benefits from fundraisers held for the person
11 in cases of serious illness, as long as neither the person nor
12 members of the person's family have actual control over the
13 donations or benefits or the disbursement of the donations or
14 benefits.

15 Notwithstanding any other provision of this Code, if the
16 United States Supreme Court holds Title II, Subtitle A, Section
17 2001(a) of Public Law 111-148 to be unconstitutional, or if a
18 holding of Public Law 111-148 makes Medicaid eligibility
19 allowed under Section 2001(a) inoperable, the State or a unit
20 of local government shall be prohibited from enrolling
21 individuals in the Medical Assistance Program as the result of
22 federal approval of a State Medicaid waiver on or after the
23 effective date of this amendatory Act of the 97th General
24 Assembly, and any individuals enrolled in the Medical
25 Assistance Program pursuant to eligibility permitted as a
26 result of such a State Medicaid waiver shall become immediately

1 ineligible.

2 Notwithstanding any other provision of this Code, if an Act
3 of Congress that becomes a Public Law eliminates Section
4 2001(a) of Public Law 111-148, the State or a unit of local
5 government shall be prohibited from enrolling individuals in
6 the Medical Assistance Program as the result of federal
7 approval of a State Medicaid waiver on or after the effective
8 date of this amendatory Act of the 97th General Assembly, and
9 any individuals enrolled in the Medical Assistance Program
10 pursuant to eligibility permitted as a result of such a State
11 Medicaid waiver shall become immediately ineligible.

12 (Source: P.A. 96-20, eff. 6-30-09; 96-181, eff. 8-10-09;
13 96-328, eff. 8-11-09; 96-567, eff. 1-1-10; 96-1000, eff.
14 7-2-10; 96-1123, eff. 1-1-11; 96-1270, eff. 7-26-10; 97-48,
15 eff. 6-28-11; 97-74, eff. 6-30-11; 97-333, eff. 8-12-11;
16 revised 10-4-11.)

17 (305 ILCS 5/5-2b new)

18 Sec. 5-2b. Medically fragile and technology dependent
19 children eligibility and program. Notwithstanding any other
20 provision of law, on and after September 1, 2012, subject to
21 federal approval, medical assistance under this Article shall
22 be available to children who qualify as persons with a
23 disability, as defined under the federal Supplemental Security
24 Income program and who are medically fragile and technology
25 dependent. The program shall allow eligible children to receive

1 the medical assistance provided under this Article in the
2 community, shall be limited to families with income up to 500%
3 of the federal poverty level, and must maximize, to the fullest
4 extent permissible under federal law, federal reimbursement
5 and family cost-sharing, including co-pays, premiums, or any
6 other family contributions, except that the Department shall be
7 permitted to incentivize the utilization of selected services
8 through the use of cost-sharing adjustments. The Department
9 shall establish the policies, procedures, standards, services,
10 and criteria for this program by rule.

11 (305 ILCS 5/5-2.03)

12 Sec. 5-2.03. Presumptive eligibility. Beginning on the
13 effective date of this amendatory Act of the 96th General
14 Assembly and except where federal law requires presumptive
15 eligibility, no adult may be presumed eligible for medical
16 assistance under this Code and the Department may not cover any
17 service rendered to an adult unless the adult has completed an
18 application for benefits, all required verifications have been
19 received, and the Department or its designee has found the
20 adult eligible for the date on which that service was provided.
21 Nothing in this Section shall apply to pregnant women or to
22 persons enrolled under the medical assistance program due to
23 expansions approved by the federal government that are financed
24 entirely by units of local government and federal matching
25 funds.

1 (Source: P.A. 96-1501, eff. 1-25-11.)

2 (305 ILCS 5/5-2.1d new)

3 Sec. 5-2.1d. Retroactive eligibility. An applicant for
4 medical assistance may be eligible for up to 3 months prior to
5 the date of application if the person would have been eligible
6 for medical assistance at the time he or she received the
7 services if he or she had applied, regardless of whether the
8 individual is alive when the application for medical assistance
9 is made. In determining financial eligibility for medical
10 assistance for retroactive months, the Department shall
11 consider the amount of income and resources and exemptions
12 available to a person as of the first day of each of the
13 backdated months for which eligibility is sought.

14 (305 ILCS 5/5-4) (from Ch. 23, par. 5-4)

15 Sec. 5-4. Amount and nature of medical assistance.

16 (a) The amount and nature of medical assistance shall be
17 determined ~~by the County Departments~~ in accordance with the
18 standards, rules, and regulations of the Department of
19 Healthcare and Family Services, with due regard to the
20 requirements and conditions in each case, including
21 contributions available from legally responsible relatives.
22 However, the amount and nature of such medical assistance shall
23 not be affected by the payment of any grant under the Senior
24 Citizens and Disabled Persons Property Tax Relief ~~and~~

1 ~~Pharmaceutical Assistance~~ Act or any distributions or items of
2 income described under subparagraph (X) of paragraph (2) of
3 subsection (a) of Section 203 of the Illinois Income Tax Act.
4 The amount and nature of medical assistance shall not be
5 affected by the receipt of donations or benefits from
6 fundraisers in cases of serious illness, as long as neither the
7 person nor members of the person's family have actual control
8 over the donations or benefits or the disbursement of the
9 donations or benefits.

10 In determining the income and resources ~~assets~~ available to
11 the institutionalized spouse and to the community spouse, the
12 Department of Healthcare and Family Services shall follow the
13 procedures established by federal law. If an institutionalized
14 spouse or community spouse refuses to comply with the
15 requirements of Title XIX of the federal Social Security Act
16 and the regulations duly promulgated thereunder by failing to
17 provide the total value of assets, including income and
18 resources, to the extent either the institutionalized spouse or
19 community spouse has an ownership interest in them pursuant to
20 42 U.S.C. 1396r-5, such refusal may result in the
21 institutionalized spouse being denied eligibility and
22 continuing to remain ineligible for the medical assistance
23 program based on failure to cooperate.

24 Subject to federal approval, the ~~The~~ community spouse
25 resource allowance shall be established and maintained at the
26 minimum ~~maximum~~ level permitted pursuant to Section 1924(f)(2)

1 of the Social Security Act, as now or hereafter amended, or an
2 amount set after a fair hearing, whichever is greater. The
3 monthly maintenance allowance for the community spouse shall be
4 established and maintained at the minimum ~~maximum~~ level
5 permitted pursuant to Section 1924(d)(3)(C) of the Social
6 Security Act, as now or hereafter amended. Subject to the
7 approval of the Secretary of the United States Department of
8 Health and Human Services, the provisions of this Section shall
9 be extended to persons who but for the provision of home or
10 community-based services under Section 4.02 of the Illinois Act
11 on the Aging, would require the level of care provided in an
12 institution, as is provided for in federal law.

13 (b) Spousal support for institutionalized spouses
14 receiving medical assistance.

15 (i) The Department may seek support for an
16 institutionalized spouse, who has assigned his or her right
17 of support from his or her spouse to the State, from the
18 resources and income available to the community spouse.

19 (ii) The Department may bring an action in the circuit
20 court to establish support orders or itself establish
21 administrative support orders by any means and procedures
22 authorized in this Code, as applicable, except that the
23 standard and regulations for determining ability to
24 support in Section 10-3 shall not limit the amount of
25 support that may be ordered.

26 (iii) Proceedings may be initiated to obtain support,

1 or for the recovery of aid granted during the period such
2 support was not provided, or both, for the obtainment of
3 support and the recovery of the aid provided. Proceedings
4 for the recovery of aid may be taken separately or they may
5 be consolidated with actions to obtain support. Such
6 proceedings may be brought in the name of the person or
7 persons requiring support or may be brought in the name of
8 the Department, as the case requires.

9 (iv) The orders for the payment of moneys for the
10 support of the person shall be just and equitable and may
11 direct payment thereof for such period or periods of time
12 as the circumstances require, including support for a
13 period before the date the order for support is entered. In
14 no event shall the orders reduce the community spouse
15 resource allowance below the level established in
16 subsection (a) of this Section or an amount set after a
17 fair hearing, whichever is greater, or reduce the monthly
18 maintenance allowance for the community spouse below the
19 level permitted pursuant to subsection (a) of this Section.

20 ~~The Department of Human Services shall notify in writing~~
21 ~~each institutionalized spouse who is a recipient of medical~~
22 ~~assistance under this Article, and each such person's community~~
23 ~~spouse, of the changes in treatment of income and resources,~~
24 ~~including provisions for protecting income for a community~~
25 ~~spouse and permitting the transfer of resources to a community~~
26 ~~spouse, required by enactment of the federal Medicare~~

1 ~~Catastrophic Coverage Act of 1988 (Public Law 100-360). The~~
2 ~~notification shall be in language likely to be easily~~
3 ~~understood by those persons. The Department of Human Services~~
4 ~~also shall reassess the amount of medical assistance for which~~
5 ~~each such recipient is eligible as a result of the enactment of~~
6 ~~that federal Act, whether or not a recipient requests such a~~
7 ~~reassessment.~~

8 (Source: P.A. 95-331, eff. 8-21-07.)

9 (305 ILCS 5/5-4.1) (from Ch. 23, par. 5-4.1)

10 Sec. 5-4.1. Co-payments. The Department may by rule provide
11 that recipients under any Article of this Code shall pay a fee
12 as a co-payment for services. Co-payments shall be maximized to
13 the extent permitted by federal law, except that the Department
14 shall impose a co-pay of \$2 on generic drugs. Provided,
15 however, that any such rule must provide that no co-payment
16 requirement can exist for renal dialysis, radiation therapy,
17 cancer chemotherapy, or insulin, and other products necessary
18 on a recurring basis, the absence of which would be life
19 threatening, or where co-payment expenditures for required
20 services and/or medications for chronic diseases that the
21 Illinois Department shall by rule designate shall cause an
22 extensive financial burden on the recipient, and provided no
23 co-payment shall exist for emergency room encounters which are
24 for medical emergencies. The Department shall seek approval of
25 a State plan amendment that allows pharmacies to refuse to

1 dispense drugs in circumstances where the recipient does not
2 pay the required co-payment. ~~In the event the State plan~~
3 ~~amendment is rejected, co-payments may not exceed \$3 for brand~~
4 ~~name drugs, \$1 for other pharmacy services other than for~~
5 ~~generic drugs, and \$2 for physician services, dental services,~~
6 ~~optical services and supplies, chiropractic services, podiatry~~
7 ~~services, and encounter rate clinic services. There shall be no~~
8 ~~co-payment for generic drugs.~~ Co-payments may not exceed \$10
9 for emergency room use for a non-emergency situation as defined
10 by the Department by rule and subject to federal approval.

11 (Source: P.A. 96-1501, eff. 1-25-11; 97-74, eff. 6-30-11.)

12 (305 ILCS 5/5-4.2) (from Ch. 23, par. 5-4.2)

13 Sec. 5-4.2. Ambulance services payments.

14 (a) For ambulance services provided to a recipient of aid
15 under this Article on or after January 1, 1993, the Illinois
16 Department shall reimburse ambulance service providers at
17 rates calculated in accordance with this Section. It is the
18 intent of the General Assembly to provide adequate
19 reimbursement for ambulance services so as to ensure adequate
20 access to services for recipients of aid under this Article and
21 to provide appropriate incentives to ambulance service
22 providers to provide services in an efficient and
23 cost-effective manner. Thus, it is the intent of the General
24 Assembly that the Illinois Department implement a
25 reimbursement system for ambulance services that, to the extent

1 practicable and subject to the availability of funds
2 appropriated by the General Assembly for this purpose, is
3 consistent with the payment principles of Medicare. To ensure
4 uniformity between the payment principles of Medicare and
5 Medicaid, the Illinois Department shall follow, to the extent
6 necessary and practicable and subject to the availability of
7 funds appropriated by the General Assembly for this purpose,
8 the statutes, laws, regulations, policies, procedures,
9 principles, definitions, guidelines, and manuals used to
10 determine the amounts paid to ambulance service providers under
11 Title XVIII of the Social Security Act (Medicare).

12 (b) For ambulance services provided to a recipient of aid
13 under this Article on or after January 1, 1996, the Illinois
14 Department shall reimburse ambulance service providers based
15 upon the actual distance traveled if a natural disaster,
16 weather conditions, road repairs, or traffic congestion
17 necessitates the use of a route other than the most direct
18 route.

19 (c) For purposes of this Section, "ambulance services"
20 includes medical transportation services provided by means of
21 an ambulance, medi-car, service car, or taxi.

22 (c-1) For purposes of this Section, "ground ambulance
23 service" means medical transportation services that are
24 described as ground ambulance services by the Centers for
25 Medicare and Medicaid Services and provided in a vehicle that
26 is licensed as an ambulance by the Illinois Department of

1 Public Health pursuant to the Emergency Medical Services (EMS)
2 Systems Act.

3 (c-2) For purposes of this Section, "ground ambulance
4 service provider" means a vehicle service provider as described
5 in the Emergency Medical Services (EMS) Systems Act that
6 operates licensed ambulances for the purpose of providing
7 emergency ambulance services, or non-emergency ambulance
8 services, or both. For purposes of this Section, this includes
9 both ambulance providers and ambulance suppliers as described
10 by the Centers for Medicare and Medicaid Services.

11 (d) This Section does not prohibit separate billing by
12 ambulance service providers for oxygen furnished while
13 providing advanced life support services.

14 (e) Beginning with services rendered on or after July 1,
15 2008, all providers of non-emergency medi-car and service car
16 transportation must certify that the driver and employee
17 attendant, as applicable, have completed a safety program
18 approved by the Department to protect both the patient and the
19 driver, prior to transporting a patient. The provider must
20 maintain this certification in its records. The provider shall
21 produce such documentation upon demand by the Department or its
22 representative. Failure to produce documentation of such
23 training shall result in recovery of any payments made by the
24 Department for services rendered by a non-certified driver or
25 employee attendant. Medi-car and service car providers must
26 maintain legible documentation in their records of the driver

1 and, as applicable, employee attendant that actually
2 transported the patient. Providers must recertify all drivers
3 and employee attendants every 3 years.

4 Notwithstanding the requirements above, any public
5 transportation provider of medi-car and service car
6 transportation that receives federal funding under 49 U.S.C.
7 5307 and 5311 need not certify its drivers and employee
8 attendants under this Section, since safety training is already
9 federally mandated.

10 (f) With respect to any policy or program administered by
11 the Department or its agent regarding approval of non-emergency
12 medical transportation by ground ambulance service providers,
13 including, but not limited to, the Non-Emergency
14 Transportation Services Prior Approval Program (NETSPAP), the
15 Department shall establish by rule a process by which ground
16 ambulance service providers of non-emergency medical
17 transportation may appeal any decision by the Department or its
18 agent for which no denial was received prior to the time of
19 transport that either (i) denies a request for approval for
20 payment of non-emergency transportation by means of ground
21 ambulance service or (ii) grants a request for approval of
22 non-emergency transportation by means of ground ambulance
23 service at a level of service that entitles the ground
24 ambulance service provider to a lower level of compensation
25 from the Department than the ground ambulance service provider
26 would have received as compensation for the level of service

1 requested. The rule shall be filed by December 15, 2012
2 ~~established within 12 months after the effective date of this~~
3 ~~amendatory Act of the 97th General Assembly~~ and shall provide
4 that, for any decision rendered by the Department or its agent
5 on or after the date the rule takes effect, the ground
6 ambulance service provider shall have 60 days from the date the
7 decision is received to file an appeal. The rule established by
8 the Department shall be, insofar as is practical, consistent
9 with the Illinois Administrative Procedure Act. The Director's
10 decision on an appeal under this Section shall be a final
11 administrative decision subject to review under the
12 Administrative Review Law.

13 (g) Whenever a patient covered by a medical assistance
14 program under this Code or by another medical program
15 administered by the Department is being discharged from a
16 facility, a physician discharge order as described in this
17 Section shall be required for each patient whose discharge
18 requires medically supervised ground ambulance services.
19 Facilities shall develop procedures for a physician with
20 medical staff privileges to provide a written and signed
21 physician discharge order. The physician discharge order shall
22 specify the level of ground ambulance services needed and
23 complete a medical certification establishing the criteria for
24 approval of non-emergency ambulance transportation, as
25 published by the Department of Healthcare and Family Services,
26 that is met by the patient. This order and the medical

1 certification shall be completed prior to ordering an ambulance
2 service and prior to patient discharge.

3 Pursuant to subsection (E) of Section 12-4.25 of this Code,
4 the Department is entitled to recover overpayments paid to a
5 provider or vendor, including, but not limited to, from the
6 discharging physician, the discharging facility, and the
7 ground ambulance service provider, in instances where a
8 non-emergency ground ambulance service is rendered as the
9 result of improper or false certification.

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

15 (Source: P.A. 97-584, eff. 8-26-11.)

16 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

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

1 or elsewhere; (6) medical care, or any other type of remedial
2 care furnished by licensed practitioners; (7) home health care
3 services; (8) private duty nursing service; (9) clinic
4 services; (10) dental services, including prevention and
5 treatment of periodontal disease and dental caries disease for
6 pregnant women, provided by an individual licensed to practice
7 dentistry or dental surgery; for purposes of this item (10),
8 "dental services" means diagnostic, preventive, or corrective
9 procedures provided by or under the supervision of a dentist in
10 the practice of his or her profession; (11) physical therapy
11 and related services; (12) prescribed drugs, dentures, and
12 prosthetic devices; and eyeglasses prescribed by a physician
13 skilled in the diseases of the eye, or by an optometrist,
14 whichever the person may select; (13) other diagnostic,
15 screening, preventive, and rehabilitative services, for
16 children and adults; (14) transportation and such other
17 expenses as may be necessary; (15) medical treatment of sexual
18 assault survivors, as defined in Section 1a of the Sexual
19 Assault Survivors Emergency Treatment Act, for injuries
20 sustained as a result of the sexual assault, including
21 examinations and laboratory tests to discover evidence which
22 may be used in criminal proceedings arising from the sexual
23 assault; (16) the diagnosis and treatment of sickle cell
24 anemia; and (17) any other medical care, and any other type of
25 remedial care recognized under the laws of this State, but not
26 including abortions, or induced miscarriages or premature

1 births, unless, in the opinion of a physician, such procedures
2 are necessary for the preservation of the life of the woman
3 seeking such treatment, or except an induced premature birth
4 intended to produce a live viable child and such procedure is
5 necessary for the health of the mother or her unborn child. The
6 Illinois Department, by rule, shall prohibit any physician from
7 providing medical assistance to anyone eligible therefor under
8 this Code where such physician has been found guilty of
9 performing an abortion procedure in a wilful and wanton manner
10 upon a woman who was not pregnant at the time such abortion
11 procedure was performed. The term "any other type of remedial
12 care" shall include nursing care and nursing home service for
13 persons who rely on treatment by spiritual means alone through
14 prayer for healing.

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

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

1 other appropriate requirements regarding laboratory test order
2 documentation.

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

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

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

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

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

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

11 The Illinois Department shall authorize the provision of,
12 and shall authorize payment for, screening by low-dose
13 mammography for the presence of occult breast cancer for women
14 35 years of age or older who are eligible for medical
15 assistance under this Article, as follows:

16 (A) A baseline mammogram for women 35 to 39 years of
17 age.

18 (B) An annual mammogram for women 40 years of age or
19 older.

20 (C) A mammogram at the age and intervals considered
21 medically necessary by the woman's health care provider for
22 women under 40 years of age and having a family history of
23 breast cancer, prior personal history of breast cancer,
24 positive genetic testing, or other risk factors.

25 (D) A comprehensive ultrasound screening of an entire
26 breast or breasts if a mammogram demonstrates

1 heterogeneous or dense breast tissue, when medically
2 necessary as determined by a physician licensed to practice
3 medicine in all of its branches.

4 All screenings shall include a physical breast exam,
5 instruction on self-examination and information regarding the
6 frequency of self-examination and its value as a preventative
7 tool. For purposes of this Section, "low-dose mammography"
8 means the x-ray examination of the breast using equipment
9 dedicated specifically for mammography, including the x-ray
10 tube, filter, compression device, and image receptor, with an
11 average radiation exposure delivery of less than one rad per
12 breast for 2 views of an average size breast. The term also
13 includes digital mammography.

14 On and after January 1, 2012, providers participating in a
15 quality improvement program approved by the Department shall be
16 reimbursed for screening and diagnostic mammography at the same
17 rate as the Medicare program's rates, including the increased
18 reimbursement for digital mammography.

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

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

1 hospital-based mammography facilities.

2 The Department shall establish a methodology to remind
3 women who are age-appropriate for screening mammography, but
4 who have not received a mammogram within the previous 18
5 months, of the importance and benefit of screening mammography.

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

12 The Department shall devise a means of case-managing or
13 patient navigation for beneficiaries diagnosed with breast
14 cancer. This program shall initially operate as a pilot program
15 in areas of the State with the highest incidence of mortality
16 related to breast cancer. At least one pilot program site shall
17 be in the metropolitan Chicago area and at least one site shall
18 be outside the metropolitan Chicago area. An evaluation of the
19 pilot program shall be carried out measuring health outcomes
20 and cost of care for those served by the pilot program compared
21 to similarly situated patients who are not served by the pilot
22 program.

23 Any medical or health care provider shall immediately
24 recommend, to any pregnant woman who is being provided prenatal
25 services and is suspected of drug abuse or is addicted as
26 defined in the Alcoholism and Other Drug Abuse and Dependency

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

9 All medical providers providing medical assistance to
10 pregnant women under this Code shall receive information from
11 the Department on the availability of services under the Drug
12 Free Families with a Future or any comparable program providing
13 case management services for addicted women, including
14 information on appropriate referrals for other social services
15 that may be needed by addicted women in addition to treatment
16 for addiction.

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

25 Neither the Department of Healthcare and Family Services
26 nor the Department of Human Services shall sanction the

1 recipient solely on the basis of her substance abuse.

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

11 ~~Notwithstanding any other provision of law, a health care~~
12 ~~provider under the medical assistance program may elect, in~~
13 ~~lieu of receiving direct payment for services provided under~~
14 ~~that program, to participate in the State Employees Deferred~~
15 ~~Compensation Plan adopted under Article 24 of the Illinois~~
16 ~~Pension Code. A health care provider who elects to participate~~
17 ~~in the plan does not have a cause of action against the State~~
18 ~~for any damages allegedly suffered by the provider as a result~~
19 ~~of any delay by the State in crediting the amount of any~~
20 ~~contribution to the provider's plan account.~~

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

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

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

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

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

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

26 Medical providers shall be required to meet certain

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

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

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

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

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

1 amendatory Act of 1984, the Illinois Department shall establish
2 a current list of acquisition costs for all prosthetic devices
3 and any other items recognized as medical equipment and
4 supplies reimbursable under this Article and shall update such
5 list on a quarterly basis, except that the acquisition costs of
6 all prescription drugs shall be updated no less frequently than
7 every 30 days as required by Section 5-5.12.

8 The rules and regulations of the Illinois Department shall
9 require that a written statement including the required opinion
10 of a physician shall accompany any claim for reimbursement for
11 abortions, or induced miscarriages or premature births. This
12 statement shall indicate what procedures were used in providing
13 such medical services.

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

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

1 by rule establish, all inquiries from clients and attorneys
2 regarding medical bills paid by the Illinois Department, which
3 inquiries could indicate potential existence of claims or liens
4 for the Illinois Department.

5 Enrollment of a vendor ~~that provides non emergency medical~~
6 ~~transportation, defined by the Department by rule,~~ shall be
7 subject to a provisional period and shall be conditional for
8 one year 180 days. During the period of conditional enrollment
9 ~~that time,~~ the Department ~~of Healthcare and Family Services~~ may
10 terminate the vendor's eligibility to participate in, or may
11 disenroll the vendor from, the medical assistance program
12 without cause. Unless otherwise specified, such ~~That~~
13 termination of eligibility or disenrollment is not subject to
14 the Department's hearing process. However, a disenrolled
15 vendor may reapply without penalty.

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

19 Prior to enrollment and during the conditional enrollment
20 period in the medical assistance program, all vendors shall be
21 subject to enhanced oversight, screening, and review based on
22 the risk of fraud, waste, and abuse that is posed by the
23 category of risk of the vendor. The Illinois Department shall
24 establish the procedures for oversight, screening, and review,
25 which may include, but need not be limited to: criminal and
26 financial background checks; fingerprinting; license,

1 certification, and authorization verifications; unscheduled or
2 unannounced site visits; database checks; prepayment audit
3 reviews; audits; payment caps; payment suspensions; and other
4 screening as required by federal or State law.

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

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

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

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

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

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

15 In the case of long term care facilities, admission
16 documents shall be submitted within 30 days of an admission to
17 the facility through the Medical Electronic Data Interchange
18 (MEDI) or the Recipient Eligibility Verification (REV) System,
19 or shall be submitted directly to the Department of Human
20 Services using required admission forms. Confirmation numbers
21 assigned to an accepted transaction shall be retained by a
22 facility to verify timely submittal. Once an admission
23 transaction has been completed, all resubmitted claims
24 following prior rejection are subject to receipt no later than
25 180 days after the admission transaction has been completed.

26 Claims that are not submitted and received in compliance

1 with the foregoing requirements shall not be eligible for
2 payment under the medical assistance program, and the State
3 shall have no liability for payment of those claims.

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

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

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

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

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

1 replacement of such devices by recipients ~~without medical~~
2 ~~authorization~~; and (2) rental, lease, purchase or
3 lease-purchase of durable medical equipment in a
4 cost-effective manner, taking into consideration the
5 recipient's medical prognosis, the extent of the recipient's
6 needs, and the requirements and costs for maintaining such
7 equipment. Subject to prior approval, such ~~Such~~ rules shall
8 enable a recipient to temporarily acquire and use alternative
9 or substitute devices or equipment pending repairs or
10 replacements of any device or equipment previously authorized
11 for such recipient by the Department.

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

1 effectuate a similar savings amount for this population; and
2 (iv) no later than July 1, 2013, minimum level of care
3 eligibility criteria for institutional and home and
4 community-based long term care. In order to select the minimum
5 level of care eligibility criteria, the Governor shall
6 establish a workgroup that includes affected agency
7 representatives and stakeholders representing the
8 institutional and home and community-based long term care
9 interests.

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

17 The Illinois Department shall report annually to the
18 General Assembly, no later than the second Friday in April of
19 1979 and each year thereafter, in regard to:

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

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

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

26 (d) efforts at utilization review and control by the

1 Illinois Department.

2 The period covered by each report shall be the 3 years
3 ending on the June 30 prior to the report. The report shall
4 include suggested legislation for consideration by the General
5 Assembly. The filing of one copy of the report with the
6 Speaker, one copy with the Minority Leader and one copy with
7 the Clerk of the House of Representatives, one copy with the
8 President, one copy with the Minority Leader and one copy with
9 the Secretary of the Senate, one copy with the Legislative
10 Research Unit, and such additional copies with the State
11 Government Report Distribution Center for the General Assembly
12 as is required under paragraph (t) of Section 7 of the State
13 Library Act shall be deemed sufficient to comply with this
14 Section.

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

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

26 (Source: P.A. 96-156, eff. 1-1-10; 96-806, eff. 7-1-10; 96-926,

1 eff. 1-1-11; 96-1000, eff. 7-2-10; 97-48, eff. 6-28-11; 97-638,
2 eff. 1-1-12.)

3 (305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

4 Sec. 5-5.02. Hospital reimbursements.

5 (a) Reimbursement to Hospitals; July 1, 1992 through
6 September 30, 1992. Notwithstanding any other provisions of
7 this Code or the Illinois Department's Rules promulgated under
8 the Illinois Administrative Procedure Act, reimbursement to
9 hospitals for services provided during the period July 1, 1992
10 through September 30, 1992, shall be as follows:

11 (1) For inpatient hospital services rendered, or if
12 applicable, for inpatient hospital discharges occurring,
13 on or after July 1, 1992 and on or before September 30,
14 1992, the Illinois Department shall reimburse hospitals
15 for inpatient services under the reimbursement
16 methodologies in effect for each hospital, and at the
17 inpatient payment rate calculated for each hospital, as of
18 June 30, 1992. For purposes of this paragraph,
19 "reimbursement methodologies" means all reimbursement
20 methodologies that pertain to the provision of inpatient
21 hospital services, including, but not limited to, any
22 adjustments for disproportionate share, targeted access,
23 critical care access and uncompensated care, as defined by
24 the Illinois Department on June 30, 1992.

25 (2) For the purpose of calculating the inpatient

1 payment rate for each hospital eligible to receive
2 quarterly adjustment payments for targeted access and
3 critical care, as defined by the Illinois Department on
4 June 30, 1992, the adjustment payment for the period July
5 1, 1992 through September 30, 1992, shall be 25% of the
6 annual adjustment payments calculated for each eligible
7 hospital, as of June 30, 1992. The Illinois Department
8 shall determine by rule the adjustment payments for
9 targeted access and critical care beginning October 1,
10 1992.

11 (3) For the purpose of calculating the inpatient
12 payment rate for each hospital eligible to receive
13 quarterly adjustment payments for uncompensated care, as
14 defined by the Illinois Department on June 30, 1992, the
15 adjustment payment for the period August 1, 1992 through
16 September 30, 1992, shall be one-sixth of the total
17 uncompensated care adjustment payments calculated for each
18 eligible hospital for the uncompensated care rate year, as
19 defined by the Illinois Department, ending on July 31,
20 1992. The Illinois Department shall determine by rule the
21 adjustment payments for uncompensated care beginning
22 October 1, 1992.

23 (b) Inpatient payments. For inpatient services provided on
24 or after October 1, 1993, in addition to rates paid for
25 hospital inpatient services pursuant to the Illinois Health
26 Finance Reform Act, as now or hereafter amended, or the

1 Illinois Department's prospective reimbursement methodology,
2 or any other methodology used by the Illinois Department for
3 inpatient services, the Illinois Department shall make
4 adjustment payments, in an amount calculated pursuant to the
5 methodology described in paragraph (c) of this Section, to
6 hospitals that the Illinois Department determines satisfy any
7 one of the following requirements:

8 (1) Hospitals that are described in Section 1923 of the
9 federal Social Security Act, as now or hereafter amended;

10 or

11 (2) Illinois hospitals that have a Medicaid inpatient
12 utilization rate which is at least one-half a standard
13 deviation above the mean Medicaid inpatient utilization
14 rate for all hospitals in Illinois receiving Medicaid
15 payments from the Illinois Department; or

16 (3) Illinois hospitals that on July 1, 1991 had a
17 Medicaid inpatient utilization rate, as defined in
18 paragraph (h) of this Section, that was at least the mean
19 Medicaid inpatient utilization rate for all hospitals in
20 Illinois receiving Medicaid payments from the Illinois
21 Department and which were located in a planning area with
22 one-third or fewer excess beds as determined by the Health
23 Facilities and Services Review Board, and that, as of June
24 30, 1992, were located in a federally designated Health
25 Manpower Shortage Area; or

26 (4) Illinois hospitals that:

1 (A) have a Medicaid inpatient utilization rate
2 that is at least equal to the mean Medicaid inpatient
3 utilization rate for all hospitals in Illinois
4 receiving Medicaid payments from the Department; and

5 (B) also have a Medicaid obstetrical inpatient
6 utilization rate that is at least one standard
7 deviation above the mean Medicaid obstetrical
8 inpatient utilization rate for all hospitals in
9 Illinois receiving Medicaid payments from the
10 Department for obstetrical services; or

11 (5) Any children's hospital, which means a hospital
12 devoted exclusively to caring for children. A hospital
13 which includes a facility devoted exclusively to caring for
14 children shall be considered a children's hospital to the
15 degree that the hospital's Medicaid care is provided to
16 children if either (i) the facility devoted exclusively to
17 caring for children is separately licensed as a hospital by
18 a municipality prior to September 30, 1998 or (ii) the
19 hospital has been designated by the State as a Level III
20 perinatal care facility, has a Medicaid Inpatient
21 Utilization rate greater than 55% for the rate year 2003
22 disproportionate share determination, and has more than
23 10,000 qualified children days as defined by the Department
24 in rulemaking.

25 (c) Inpatient adjustment payments. The adjustment payments
26 required by paragraph (b) shall be calculated based upon the

1 hospital's Medicaid inpatient utilization rate as follows:

2 (1) hospitals with a Medicaid inpatient utilization
3 rate below the mean shall receive a per day adjustment
4 payment equal to \$25;

5 (2) hospitals with a Medicaid inpatient utilization
6 rate that is equal to or greater than the mean Medicaid
7 inpatient utilization rate but less than one standard
8 deviation above the mean Medicaid inpatient utilization
9 rate shall receive a per day adjustment payment equal to
10 the sum of \$25 plus \$1 for each one percent that the
11 hospital's Medicaid inpatient utilization rate exceeds the
12 mean Medicaid inpatient utilization rate;

13 (3) hospitals with a Medicaid inpatient utilization
14 rate that is equal to or greater than one standard
15 deviation above the mean Medicaid inpatient utilization
16 rate but less than 1.5 standard deviations above the mean
17 Medicaid inpatient utilization rate shall receive a per day
18 adjustment payment equal to the sum of \$40 plus \$7 for each
19 one percent that the hospital's Medicaid inpatient
20 utilization rate exceeds one standard deviation above the
21 mean Medicaid inpatient utilization rate; and

22 (4) hospitals with a Medicaid inpatient utilization
23 rate that is equal to or greater than 1.5 standard
24 deviations above the mean Medicaid inpatient utilization
25 rate shall receive a per day adjustment payment equal to
26 the sum of \$90 plus \$2 for each one percent that the

1 hospital's Medicaid inpatient utilization rate exceeds 1.5
2 standard deviations above the mean Medicaid inpatient
3 utilization rate.

4 (d) Supplemental adjustment payments. In addition to the
5 adjustment payments described in paragraph (c), hospitals as
6 defined in clauses (1) through (5) of paragraph (b), excluding
7 county hospitals (as defined in subsection (c) of Section 15-1
8 of this Code) and a hospital organized under the University of
9 Illinois Hospital Act, shall be paid supplemental inpatient
10 adjustment payments of \$60 per day. For purposes of Title XIX
11 of the federal Social Security Act, these supplemental
12 adjustment payments shall not be classified as adjustment
13 payments to disproportionate share hospitals.

14 (e) The inpatient adjustment payments described in
15 paragraphs (c) and (d) shall be increased on October 1, 1993
16 and annually thereafter by a percentage equal to the lesser of
17 (i) the increase in the DRI hospital cost index for the most
18 recent 12 month period for which data are available, or (ii)
19 the percentage increase in the statewide average hospital
20 payment rate over the previous year's statewide average
21 hospital payment rate. The sum of the inpatient adjustment
22 payments under paragraphs (c) and (d) to a hospital, other than
23 a county hospital (as defined in subsection (c) of Section 15-1
24 of this Code) or a hospital organized under the University of
25 Illinois Hospital Act, however, shall not exceed \$275 per day;
26 that limit shall be increased on October 1, 1993 and annually

1 thereafter by a percentage equal to the lesser of (i) the
2 increase in the DRI hospital cost index for the most recent
3 12-month period for which data are available or (ii) the
4 percentage increase in the statewide average hospital payment
5 rate over the previous year's statewide average hospital
6 payment rate.

7 (f) Children's hospital inpatient adjustment payments. For
8 children's hospitals, as defined in clause (5) of paragraph
9 (b), the adjustment payments required pursuant to paragraphs
10 (c) and (d) shall be multiplied by 2.0.

11 (g) County hospital inpatient adjustment payments. For
12 county hospitals, as defined in subsection (c) of Section 15-1
13 of this Code, there shall be an adjustment payment as
14 determined by rules issued by the Illinois Department.

15 (h) For the purposes of this Section the following terms
16 shall be defined as follows:

17 (1) "Medicaid inpatient utilization rate" means a
18 fraction, the numerator of which is the number of a
19 hospital's inpatient days provided in a given 12-month
20 period to patients who, for such days, were eligible for
21 Medicaid under Title XIX of the federal Social Security
22 Act, and the denominator of which is the total number of
23 the hospital's inpatient days in that same period.

24 (2) "Mean Medicaid inpatient utilization rate" means
25 the total number of Medicaid inpatient days provided by all
26 Illinois Medicaid-participating hospitals divided by the

1 total number of inpatient days provided by those same
2 hospitals.

3 (3) "Medicaid obstetrical inpatient utilization rate"
4 means the ratio of Medicaid obstetrical inpatient days to
5 total Medicaid inpatient days for all Illinois hospitals
6 receiving Medicaid payments from the Illinois Department.

7 (i) Inpatient adjustment payment limit. In order to meet
8 the limits of Public Law 102-234 and Public Law 103-66, the
9 Illinois Department shall by rule adjust disproportionate
10 share adjustment payments.

11 (j) University of Illinois Hospital inpatient adjustment
12 payments. For hospitals organized under the University of
13 Illinois Hospital Act, there shall be an adjustment payment as
14 determined by rules adopted by the Illinois Department.

15 (k) The Illinois Department may by rule establish criteria
16 for and develop methodologies for adjustment payments to
17 hospitals participating under this Article.

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

23 (Source: P.A. 96-31, eff. 6-30-09.)

24 (305 ILCS 5/5-5.05)

25 Sec. 5-5.05. Hospitals; psychiatric services.

1 (a) On and after July 1, 2008, the inpatient, per diem rate
2 to be paid to a hospital for inpatient psychiatric services
3 shall be \$363.77.

4 (b) For purposes of this Section, "hospital" means the
5 following:

6 (1) Advocate Christ Hospital, Oak Lawn, Illinois.

7 (2) Barnes-Jewish Hospital, St. Louis, Missouri.

8 (3) BroMenn Healthcare, Bloomington, Illinois.

9 (4) Jackson Park Hospital, Chicago, Illinois.

10 (5) Katherine Shaw Bethea Hospital, Dixon, Illinois.

11 (6) Lawrence County Memorial Hospital, Lawrenceville,
12 Illinois.

13 (7) Advocate Lutheran General Hospital, Park Ridge,
14 Illinois.

15 (8) Mercy Hospital and Medical Center, Chicago,
16 Illinois.

17 (9) Methodist Medical Center of Illinois, Peoria,
18 Illinois.

19 (10) Provena United Samaritans Medical Center,
20 Danville, Illinois.

21 (11) Rockford Memorial Hospital, Rockford, Illinois.

22 (12) Sarah Bush Lincoln Health Center, Mattoon,
23 Illinois.

24 (13) Provena Covenant Medical Center, Urbana,
25 Illinois.

26 (14) Rush-Presbyterian-St. Luke's Medical Center,

1 Chicago, Illinois.

2 (15) Mt. Sinai Hospital, Chicago, Illinois.

3 (16) Gateway Regional Medical Center, Granite City,
4 Illinois.

5 (17) St. Mary of Nazareth Hospital, Chicago, Illinois.

6 (18) Provena St. Mary's Hospital, Kankakee, Illinois.

7 (19) St. Mary's Hospital, Decatur, Illinois.

8 (20) Memorial Hospital, Belleville, Illinois.

9 (21) Swedish Covenant Hospital, Chicago, Illinois.

10 (22) Trinity Medical Center, Rock Island, Illinois.

11 (23) St. Elizabeth Hospital, Chicago, Illinois.

12 (24) Richland Memorial Hospital, Olney, Illinois.

13 (25) St. Elizabeth's Hospital, Belleville, Illinois.

14 (26) Samaritan Health System, Clinton, Iowa.

15 (27) St. John's Hospital, Springfield, Illinois.

16 (28) St. Mary's Hospital, Centralia, Illinois.

17 (29) Loretto Hospital, Chicago, Illinois.

18 (30) Kenneth Hall Regional Hospital, East St. Louis,
19 Illinois.

20 (31) Hinsdale Hospital, Hinsdale, Illinois.

21 (32) Pekin Hospital, Pekin, Illinois.

22 (33) University of Chicago Medical Center, Chicago,
23 Illinois.

24 (34) St. Anthony's Health Center, Alton, Illinois.

25 (35) OSF St. Francis Medical Center, Peoria, Illinois.

26 (36) Memorial Medical Center, Springfield, Illinois.

1 (37) A hospital with a distinct part unit for
2 psychiatric services that begins operating on or after July
3 1, 2008.

4 For purposes of this Section, "inpatient psychiatric
5 services" means those services provided to patients who are in
6 need of short-term acute inpatient hospitalization for active
7 treatment of an emotional or mental disorder.

8 (c) No rules shall be promulgated to implement this
9 Section. For purposes of this Section, "rules" is given the
10 meaning contained in Section 1-70 of the Illinois
11 Administrative Procedure Act.

12 (d) This Section shall not be in effect during any period
13 of time that the State has in place a fully operational
14 hospital assessment plan that has been approved by the Centers
15 for Medicare and Medicaid Services of the U.S. Department of
16 Health and Human Services.

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

22 (Source: P.A. 95-1013, eff. 12-15-08.)

23 (305 ILCS 5/5-5.2) (from Ch. 23, par. 5-5.2)
24 Sec. 5-5.2. Payment.

25 (a) All nursing facilities that are grouped pursuant to

1 Section 5-5.1 of this Act shall receive the same rate of
2 payment for similar services.

3 (b) It shall be a matter of State policy that the Illinois
4 Department shall utilize a uniform billing cycle throughout the
5 State for the long-term care providers.

6 (c) Notwithstanding any other provisions of this Code,
7 ~~beginning July 1, 2012~~ the methodologies for reimbursement of
8 nursing ~~facility~~ services as provided under this Article shall
9 no longer be applicable for bills payable for nursing services
10 rendered on or after a new reimbursement system based on the
11 Resource Utilization Groups (RUGs) has been fully
12 operationalized, which shall take effect for services provided
13 on or after January 1, 2014. ~~State fiscal years 2012 and~~
14 ~~thereafter. The Department of Healthcare and Family Services~~
15 ~~shall, effective July 1, 2012, implement an evidence based~~
16 ~~payment methodology for the reimbursement of nursing facility~~
17 ~~services. The methodology shall continue to take into~~
18 ~~consideration the needs of individual residents, as assessed~~
19 ~~and reported by the most current version of the nursing~~
20 ~~facility Resident Assessment Instrument, adopted and in use by~~
21 ~~the federal government.~~

22 (d) A new nursing services reimbursement methodology
23 utilizing RUGs IV 48 grouper model shall be established and may
24 include an Illinois-specific default group, as needed. The new
25 RUGs-based nursing services reimbursement methodology shall be
26 resident-driven, facility-specific, and cost-based. Costs

1 shall be annually rebased and case mix index quarterly updated.
2 The methodology shall include regional wage adjustors based on
3 the Health Service Areas (HSA) groupings in effect on April 30,
4 2012. The Department shall assign a case mix index to each
5 resident class based on the Centers for Medicare and Medicaid
6 Services staff time measurement study utilizing an index
7 maximization approach.

8 (e) Notwithstanding any other provision of this Code, the
9 Department shall by rule develop a reimbursement methodology
10 reflective of the intensity of care and services requirements
11 of low need residents in the lowest RUG IV groupers and
12 corresponding regulations.

13 (f) Notwithstanding any other provision of this Code, on
14 and after July 1, 2012, reimbursement rates associated with the
15 nursing or support components of the current nursing facility
16 rate methodology shall not increase beyond the level effective
17 May 1, 2011 until a new reimbursement system based on the RUGs
18 IV 48 grouper model has been fully operationalized.

19 (g) Notwithstanding any other provision of this Code, on
20 and after July 1, 2012, for facilities not designated by the
21 Department of Healthcare and Family Services as "Institutions
22 for Mental Disease" and "Institutions for Mental Disease" that
23 are facilities licensed under the Specialized Mental Health
24 Rehabilitation Act, rates effective May 1, 2011 shall be
25 adjusted as follows:

26 (1) Individual nursing rates for residents classified

1 in RUG IV groups PA1, PA2, BA1, and BA2 during the quarter
2 ending March 31, 2012 shall be reduced by 10%;

3 (2) Individual nursing rates for residents classified
4 in all other RUG IV groups shall be reduced by 1.0%;

5 (3) Facility rates for the capital and support
6 components shall be reduced by 1.7%.

7 (h) Notwithstanding any other provision of this Code, on
8 and after July 1, 2012, nursing facilities designated by the
9 Department of Healthcare and Family Services as "Institutions
10 for Mental Disease" shall have the nursing,
11 socio-developmental, capital, and support components of their
12 reimbursement rate effective May 1, 2011 reduced in total by
13 2.7%.

14 (Source: P.A. 96-1530, eff. 2-16-11.)

15 (305 ILCS 5/5-5.3) (from Ch. 23, par. 5-5.3)

16 Sec. 5-5.3. Conditions of Payment - Prospective Rates -
17 Accounting Principles. This amendatory Act establishes certain
18 conditions for the Department of Healthcare and Family Services
19 in instituting rates for the care of recipients of medical
20 assistance in nursing facilities and ICF/DDs. Such conditions
21 shall assure a method under which the payment for nursing
22 facility and ICF/DD services provided to recipients under the
23 Medical Assistance Program shall be on a reasonable cost
24 related basis, which is prospectively determined at least
25 annually by the Department of Public Aid (now Healthcare and

1 Family Services). The annually established payment rate shall
2 take effect on July 1 in 1984 and subsequent years. There shall
3 be no rate increase during calendar year 1983 and the first six
4 months of calendar year 1984.

5 The determination of the payment shall be made on the basis
6 of generally accepted accounting principles that shall take
7 into account the actual costs to the facility of providing
8 nursing facility and ICF/DD services to recipients under the
9 medical assistance program.

10 The resultant total rate for a specified type of service
11 shall be an amount which shall have been determined to be
12 adequate to reimburse allowable costs of a facility that is
13 economically and efficiently operated. The Department shall
14 establish an effective date for each facility or group of
15 facilities after which rates shall be paid on a reasonable cost
16 related basis which shall be no sooner than the effective date
17 of this amendatory Act of 1977.

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

23 (Source: P.A. 95-331, eff. 8-21-07; 96-1530, eff. 2-16-11.)

24 (305 ILCS 5/5-5.4) (from Ch. 23, par. 5-5.4)

25 Sec. 5-5.4. Standards of Payment - Department of Healthcare

1 and Family Services. The Department of Healthcare and Family
2 Services shall develop standards of payment of nursing facility
3 and ICF/DD services in facilities providing such services under
4 this Article which:

5 (1) Provide for the determination of a facility's payment
6 for nursing facility or ICF/DD services on a prospective basis.
7 The amount of the payment rate for all nursing facilities
8 certified by the Department of Public Health under the ID/DD
9 Community Care Act or the Nursing Home Care Act as Intermediate
10 Care for the Developmentally Disabled facilities, Long Term
11 Care for Under Age 22 facilities, Skilled Nursing facilities,
12 or Intermediate Care facilities under the medical assistance
13 program shall be prospectively established annually on the
14 basis of historical, financial, and statistical data
15 reflecting actual costs from prior years, which shall be
16 applied to the current rate year and updated for inflation,
17 except that the capital cost element for newly constructed
18 facilities shall be based upon projected budgets. The annually
19 established payment rate shall take effect on July 1 in 1984
20 and subsequent years. No rate increase and no update for
21 inflation shall be provided on or after July 1, 1994 and before
22 January 1, 2014 ~~July 1, 2012~~, unless specifically provided for
23 in this Section. The changes made by Public Act 93-841
24 extending the duration of the prohibition against a rate
25 increase or update for inflation are effective retroactive to
26 July 1, 2004.

1 For facilities licensed by the Department of Public Health
2 under the Nursing Home Care Act as Intermediate Care for the
3 Developmentally Disabled facilities or Long Term Care for Under
4 Age 22 facilities, the rates taking effect on July 1, 1998
5 shall include an increase of 3%. For facilities licensed by the
6 Department of Public Health under the Nursing Home Care Act as
7 Skilled Nursing facilities or Intermediate Care facilities,
8 the rates taking effect on July 1, 1998 shall include an
9 increase of 3% plus \$1.10 per resident-day, as defined by the
10 Department. For facilities licensed by the Department of Public
11 Health under the Nursing Home Care Act as Intermediate Care
12 Facilities for the Developmentally Disabled or Long Term Care
13 for Under Age 22 facilities, the rates taking effect on January
14 1, 2006 shall include an increase of 3%. For facilities
15 licensed by the Department of Public Health under the Nursing
16 Home Care Act as Intermediate Care Facilities for the
17 Developmentally Disabled or Long Term Care for Under Age 22
18 facilities, the rates taking effect on January 1, 2009 shall
19 include an increase sufficient to provide a \$0.50 per hour wage
20 increase for non-executive staff.

21 For facilities licensed by the Department of Public Health
22 under the Nursing Home Care Act as Intermediate Care for the
23 Developmentally Disabled facilities or Long Term Care for Under
24 Age 22 facilities, the rates taking effect on July 1, 1999
25 shall include an increase of 1.6% plus \$3.00 per resident-day,
26 as defined by the Department. For facilities licensed by the

1 Department of Public Health under the Nursing Home Care Act as
2 Skilled Nursing facilities or Intermediate Care facilities,
3 the rates taking effect on July 1, 1999 shall include an
4 increase of 1.6% and, for services provided on or after October
5 1, 1999, shall be increased by \$4.00 per resident-day, as
6 defined by the Department.

7 For facilities licensed by the Department of Public Health
8 under the Nursing Home Care Act as Intermediate Care for the
9 Developmentally Disabled facilities or Long Term Care for Under
10 Age 22 facilities, the rates taking effect on July 1, 2000
11 shall include an increase of 2.5% per resident-day, as defined
12 by the Department. For facilities licensed by the Department of
13 Public Health under the Nursing Home Care Act as Skilled
14 Nursing facilities or Intermediate Care facilities, the rates
15 taking effect on July 1, 2000 shall include an increase of 2.5%
16 per resident-day, as defined by the Department.

17 For facilities licensed by the Department of Public Health
18 under the Nursing Home Care Act as skilled nursing facilities
19 or intermediate care facilities, a new payment methodology must
20 be implemented for the nursing component of the rate effective
21 July 1, 2003. The Department of Public Aid (now Healthcare and
22 Family Services) shall develop the new payment methodology
23 using the Minimum Data Set (MDS) as the instrument to collect
24 information concerning nursing home resident condition
25 necessary to compute the rate. The Department shall develop the
26 new payment methodology to meet the unique needs of Illinois

1 nursing home residents while remaining subject to the
2 appropriations provided by the General Assembly. A transition
3 period from the payment methodology in effect on June 30, 2003
4 to the payment methodology in effect on July 1, 2003 shall be
5 provided for a period not exceeding 3 years and 184 days after
6 implementation of the new payment methodology as follows:

7 (A) For a facility that would receive a lower nursing
8 component rate per patient day under the new system than
9 the facility received effective on the date immediately
10 preceding the date that the Department implements the new
11 payment methodology, the nursing component rate per
12 patient day for the facility shall be held at the level in
13 effect on the date immediately preceding the date that the
14 Department implements the new payment methodology until a
15 higher nursing component rate of reimbursement is achieved
16 by that facility.

17 (B) For a facility that would receive a higher nursing
18 component rate per patient day under the payment
19 methodology in effect on July 1, 2003 than the facility
20 received effective on the date immediately preceding the
21 date that the Department implements the new payment
22 methodology, the nursing component rate per patient day for
23 the facility shall be adjusted.

24 (C) Notwithstanding paragraphs (A) and (B), the
25 nursing component rate per patient day for the facility
26 shall be adjusted subject to appropriations provided by the

1 General Assembly.

2 For facilities licensed by the Department of Public Health
3 under the Nursing Home Care Act as Intermediate Care for the
4 Developmentally Disabled facilities or Long Term Care for Under
5 Age 22 facilities, the rates taking effect on March 1, 2001
6 shall include a statewide increase of 7.85%, as defined by the
7 Department.

8 Notwithstanding any other provision of this Section, for
9 facilities licensed by the Department of Public Health under
10 the Nursing Home Care Act as skilled nursing facilities or
11 intermediate care facilities, except facilities participating
12 in the Department's demonstration program pursuant to the
13 provisions of Title 77, Part 300, Subpart T of the Illinois
14 Administrative Code, the numerator of the ratio used by the
15 Department of Healthcare and Family Services to compute the
16 rate payable under this Section using the Minimum Data Set
17 (MDS) methodology shall incorporate the following annual
18 amounts as the additional funds appropriated to the Department
19 specifically to pay for rates based on the MDS nursing
20 component methodology in excess of the funding in effect on
21 December 31, 2006:

22 (i) For rates taking effect January 1, 2007,
23 \$60,000,000.

24 (ii) For rates taking effect January 1, 2008,
25 \$110,000,000.

26 (iii) For rates taking effect January 1, 2009,

1 \$194,000,000.

2 (iv) For rates taking effect April 1, 2011, or the
3 first day of the month that begins at least 45 days after
4 the effective date of this amendatory Act of the 96th
5 General Assembly, \$416,500,000 or an amount as may be
6 necessary to complete the transition to the MDS methodology
7 for the nursing component of the rate. Increased payments
8 under this item (iv) are not due and payable, however,
9 until (i) the methodologies described in this paragraph are
10 approved by the federal government in an appropriate State
11 Plan amendment and (ii) the assessment imposed by Section
12 5B-2 of this Code is determined to be a permissible tax
13 under Title XIX of the Social Security Act.

14 Notwithstanding any other provision of this Section, for
15 facilities licensed by the Department of Public Health under
16 the Nursing Home Care Act as skilled nursing facilities or
17 intermediate care facilities, the support component of the
18 rates taking effect on January 1, 2008 shall be computed using
19 the most recent cost reports on file with the Department of
20 Healthcare and Family Services no later than April 1, 2005,
21 updated for inflation to January 1, 2006.

22 For facilities licensed by the Department of Public Health
23 under the Nursing Home Care Act as Intermediate Care for the
24 Developmentally Disabled facilities or Long Term Care for Under
25 Age 22 facilities, the rates taking effect on April 1, 2002
26 shall include a statewide increase of 2.0%, as defined by the

1 Department. This increase terminates on July 1, 2002; beginning
2 July 1, 2002 these rates are reduced to the level of the rates
3 in effect on March 31, 2002, as defined by the Department.

4 For facilities licensed by the Department of Public Health
5 under the Nursing Home Care Act as skilled nursing facilities
6 or intermediate care facilities, the rates taking effect on
7 July 1, 2001 shall be computed using the most recent cost
8 reports on file with the Department of Public Aid no later than
9 April 1, 2000, updated for inflation to January 1, 2001. For
10 rates effective July 1, 2001 only, rates shall be the greater
11 of the rate computed for July 1, 2001 or the rate effective on
12 June 30, 2001.

13 Notwithstanding any other provision of this Section, for
14 facilities licensed by the Department of Public Health under
15 the Nursing Home Care Act as skilled nursing facilities or
16 intermediate care facilities, the Illinois Department shall
17 determine by rule the rates taking effect on July 1, 2002,
18 which shall be 5.9% less than the rates in effect on June 30,
19 2002.

20 Notwithstanding any other provision of this Section, for
21 facilities licensed by the Department of Public Health under
22 the Nursing Home Care Act as skilled nursing facilities or
23 intermediate care facilities, if the payment methodologies
24 required under Section 5A-12 and the waiver granted under 42
25 CFR 433.68 are approved by the United States Centers for
26 Medicare and Medicaid Services, the rates taking effect on July

1 1, 2004 shall be 3.0% greater than the rates in effect on June
2 30, 2004. These rates shall take effect only upon approval and
3 implementation of the payment methodologies required under
4 Section 5A-12.

5 Notwithstanding any other provisions of this Section, for
6 facilities licensed by the Department of Public Health under
7 the Nursing Home Care Act as skilled nursing facilities or
8 intermediate care facilities, the rates taking effect on
9 January 1, 2005 shall be 3% more than the rates in effect on
10 December 31, 2004.

11 Notwithstanding any other provision of this Section, for
12 facilities licensed by the Department of Public Health under
13 the Nursing Home Care Act as skilled nursing facilities or
14 intermediate care facilities, effective January 1, 2009, the
15 per diem support component of the rates effective on January 1,
16 2008, computed using the most recent cost reports on file with
17 the Department of Healthcare and Family Services no later than
18 April 1, 2005, updated for inflation to January 1, 2006, shall
19 be increased to the amount that would have been derived using
20 standard Department of Healthcare and Family Services methods,
21 procedures, and inflators.

22 Notwithstanding any other provisions of this Section, for
23 facilities licensed by the Department of Public Health under
24 the Nursing Home Care Act as intermediate care facilities that
25 are federally defined as Institutions for Mental Disease, or
26 facilities licensed by the Department of Public Health under

1 the Specialized Mental Health Rehabilitation ~~Facilities~~ Act, a
2 socio-development component rate equal to 6.6% of the
3 facility's nursing component rate as of January 1, 2006 shall
4 be established and paid effective July 1, 2006. The
5 socio-development component of the rate shall be increased by a
6 factor of 2.53 on the first day of the month that begins at
7 least 45 days after January 11, 2008 (the effective date of
8 Public Act 95-707). As of August 1, 2008, the socio-development
9 component rate shall be equal to 6.6% of the facility's nursing
10 component rate as of January 1, 2006, multiplied by a factor of
11 3.53. For services provided on or after April 1, 2011, or the
12 first day of the month that begins at least 45 days after the
13 effective date of this amendatory Act of the 96th General
14 Assembly, whichever is later, the Illinois Department may by
15 rule adjust these socio-development component rates, and may
16 use different adjustment methodologies for those facilities
17 participating, and those not participating, in the Illinois
18 Department's demonstration program pursuant to the provisions
19 of Title 77, Part 300, Subpart T of the Illinois Administrative
20 Code, but in no case may such rates be diminished below those
21 in effect on August 1, 2008.

22 For facilities licensed by the Department of Public Health
23 under the Nursing Home Care Act as Intermediate Care for the
24 Developmentally Disabled facilities or as long-term care
25 facilities for residents under 22 years of age, the rates
26 taking effect on July 1, 2003 shall include a statewide

1 increase of 4%, as defined by the Department.

2 For facilities licensed by the Department of Public Health
3 under the Nursing Home Care Act as Intermediate Care for the
4 Developmentally Disabled facilities or Long Term Care for Under
5 Age 22 facilities, the rates taking effect on the first day of
6 the month that begins at least 45 days after the effective date
7 of this amendatory Act of the 95th General Assembly shall
8 include a statewide increase of 2.5%, as defined by the
9 Department.

10 Notwithstanding any other provision of this Section, for
11 facilities licensed by the Department of Public Health under
12 the Nursing Home Care Act as skilled nursing facilities or
13 intermediate care facilities, effective January 1, 2005,
14 facility rates shall be increased by the difference between (i)
15 a facility's per diem property, liability, and malpractice
16 insurance costs as reported in the cost report filed with the
17 Department of Public Aid and used to establish rates effective
18 July 1, 2001 and (ii) those same costs as reported in the
19 facility's 2002 cost report. These costs shall be passed
20 through to the facility without caps or limitations, except for
21 adjustments required under normal auditing procedures.

22 Rates established effective each July 1 shall govern
23 payment for services rendered throughout that fiscal year,
24 except that rates established on July 1, 1996 shall be
25 increased by 6.8% for services provided on or after January 1,
26 1997. Such rates will be based upon the rates calculated for

1 the year beginning July 1, 1990, and for subsequent years
2 thereafter until June 30, 2001 shall be based on the facility
3 cost reports for the facility fiscal year ending at any point
4 in time during the previous calendar year, updated to the
5 midpoint of the rate year. The cost report shall be on file
6 with the Department no later than April 1 of the current rate
7 year. Should the cost report not be on file by April 1, the
8 Department shall base the rate on the latest cost report filed
9 by each skilled care facility and intermediate care facility,
10 updated to the midpoint of the current rate year. In
11 determining rates for services rendered on and after July 1,
12 1985, fixed time shall not be computed at less than zero. The
13 Department shall not make any alterations of regulations which
14 would reduce any component of the Medicaid rate to a level
15 below what that component would have been utilizing in the rate
16 effective on July 1, 1984.

17 (2) Shall take into account the actual costs incurred by
18 facilities in providing services for recipients of skilled
19 nursing and intermediate care services under the medical
20 assistance program.

21 (3) Shall take into account the medical and psycho-social
22 characteristics and needs of the patients.

23 (4) Shall take into account the actual costs incurred by
24 facilities in meeting licensing and certification standards
25 imposed and prescribed by the State of Illinois, any of its
26 political subdivisions or municipalities and by the U.S.

1 Department of Health and Human Services pursuant to Title XIX
2 of the Social Security Act.

3 The Department of Healthcare and Family Services shall
4 develop precise standards for payments to reimburse nursing
5 facilities for any utilization of appropriate rehabilitative
6 personnel for the provision of rehabilitative services which is
7 authorized by federal regulations, including reimbursement for
8 services provided by qualified therapists or qualified
9 assistants, and which is in accordance with accepted
10 professional practices. Reimbursement also may be made for
11 utilization of other supportive personnel under appropriate
12 supervision.

13 The Department shall develop enhanced payments to offset
14 the additional costs incurred by a facility serving exceptional
15 need residents and shall allocate at least \$8,000,000 of the
16 funds collected from the assessment established by Section 5B-2
17 of this Code for such payments. For the purpose of this
18 Section, "exceptional needs" means, but need not be limited to,
19 ventilator care, tracheotomy care, bariatric care, complex
20 wound care, and traumatic brain injury care. The enhanced
21 payments for exceptional need residents under this paragraph
22 are not due and payable, however, until (i) the methodologies
23 described in this paragraph are approved by the federal
24 government in an appropriate State Plan amendment and (ii) the
25 assessment imposed by Section 5B-2 of this Code is determined
26 to be a permissible tax under Title XIX of the Social Security

1 Act.

2 ~~(5)~~ Beginning January ~~July~~ 1, 2014 ~~2012~~ the methodologies
3 for reimbursement of nursing facility services as provided
4 under this Section 5-5.4 shall no longer be applicable for
5 services provided on or after January 1, 2014 ~~bills payable for~~
6 ~~State fiscal years 2012 and thereafter.~~

7 ~~(6)~~ No payment increase under this Section for the MDS
8 methodology, exceptional care residents, or the
9 socio-development component rate established by Public Act
10 96-1530 of the 96th General Assembly and funded by the
11 assessment imposed under Section 5B-2 of this Code shall be due
12 and payable until after the Department notifies the long-term
13 care providers, in writing, that the payment methodologies to
14 long-term care providers required under this Section have been
15 approved by the Centers for Medicare and Medicaid Services of
16 the U.S. Department of Health and Human Services and the
17 waivers under 42 CFR 433.68 for the assessment imposed by this
18 Section, if necessary, have been granted by the Centers for
19 Medicare and Medicaid Services of the U.S. Department of Health
20 and Human Services. Upon notification to the Department of
21 approval of the payment methodologies required under this
22 Section and the waivers granted under 42 CFR 433.68, all
23 increased payments otherwise due under this Section prior to
24 the date of notification shall be due and payable within 90
25 days of the date federal approval is received.

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

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

5 (Source: P.A. 96-45, eff. 7-15-09; 96-339, eff. 7-1-10; 96-959,
6 eff. 7-1-10; 96-1000, eff. 7-2-10; 96-1530, eff. 2-16-11;
7 97-10, eff. 6-14-11; 97-38, eff. 6-28-11; 97-227, eff. 1-1-12;
8 97-584, eff. 8-26-11; revised 10-4-11.)

9 (305 ILCS 5/5-5.4e)

10 Sec. 5-5.4e. Nursing facilities; ventilator rates. On and
11 after October 1, 2009, the Department of Healthcare and Family
12 Services shall adopt rules to provide medical assistance
13 reimbursement under this Article for the care of persons on
14 ventilators in skilled nursing facilities licensed under the
15 Nursing Home Care Act and certified to participate under the
16 medical assistance program. Accordingly, necessary amendments
17 to the rules implementing the Minimum Data Set (MDS) payment
18 methodology shall also be made to provide a separate per diem
19 ventilator rate based on days of service. The Department may
20 adopt rules necessary to implement this amendatory Act of the
21 96th General Assembly through the use of emergency rulemaking
22 in accordance with Section 5-45 of the Illinois Administrative
23 Procedure Act, except that the 24-month limitation on the
24 adoption of emergency rules under Section 5-45 and the
25 provisions of Sections 5-115 and 5-125 of that Act do not apply

1 to rules adopted under this Section. For purposes of that Act,
2 the General Assembly finds that the adoption of rules to
3 implement this amendatory Act of the 96th General Assembly is
4 deemed an emergency and necessary for the public interest,
5 safety, and welfare.

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

11 (Source: P.A. 96-743, eff. 8-25-09.)

12 (305 ILCS 5/5-5.5) (from Ch. 23, par. 5-5.5)

13 Sec. 5-5.5. Elements of Payment Rate.

14 (a) The Department of Healthcare and Family Services shall
15 develop a prospective method for determining payment rates for
16 nursing facility and ICF/DD services in nursing facilities
17 composed of the following cost elements:

18 (1) Standard Services, with the cost of this component
19 being determined by taking into account the actual costs to
20 the facilities of these services subject to cost ceilings
21 to be defined in the Department's rules.

22 (2) Resident Services, with the cost of this component
23 being determined by taking into account the actual costs,
24 needs and utilization of these services, as derived from an
25 assessment of the resident needs in the nursing facilities.

1 (3) Ancillary Services, with the payment rate being
2 developed for each individual type of service. Payment
3 shall be made only when authorized under procedures
4 developed by the Department of Healthcare and Family
5 Services.

6 (4) Nurse's Aide Training, with the cost of this
7 component being determined by taking into account the
8 actual cost to the facilities of such training.

9 (5) Real Estate Taxes, with the cost of this component
10 being determined by taking into account the figures
11 contained in the most currently available cost reports
12 (with no imposition of maximums) updated to the midpoint of
13 the current rate year for long term care services rendered
14 between July 1, 1984 and June 30, 1985, and with the cost
15 of this component being determined by taking into account
16 the actual 1983 taxes for which the nursing homes were
17 assessed (with no imposition of maximums) updated to the
18 midpoint of the current rate year for long term care
19 services rendered between July 1, 1985 and June 30, 1986.

20 (b) In developing a prospective method for determining
21 payment rates for nursing facility and ICF/DD services in
22 nursing facilities and ICF/DDs, the Department of Healthcare
23 and Family Services shall consider the following cost elements:

24 (1) Reasonable capital cost determined by utilizing
25 incurred interest rate and the current value of the
26 investment, including land, utilizing composite rates, or

1 by utilizing such other reasonable cost related methods
2 determined by the Department. However, beginning with the
3 rate reimbursement period effective July 1, 1987, the
4 Department shall be prohibited from establishing,
5 including, and implementing any depreciation factor in
6 calculating the capital cost element.

7 (2) Profit, with the actual amount being produced and
8 accruing to the providers in the form of a return on their
9 total investment, on the basis of their ability to
10 economically and efficiently deliver a type of service. The
11 method of payment may assure the opportunity for a profit,
12 but shall not guarantee or establish a specific amount as a
13 cost.

14 (c) The Illinois Department may implement the amendatory
15 changes to this Section made by this amendatory Act of 1991
16 through the use of emergency rules in accordance with the
17 provisions of Section 5.02 of the Illinois Administrative
18 Procedure Act. For purposes of the Illinois Administrative
19 Procedure Act, the adoption of rules to implement the
20 amendatory changes to this Section made by this amendatory Act
21 of 1991 shall be deemed an emergency and necessary for the
22 public interest, safety and welfare.

23 (d) No later than January 1, 2001, the Department of Public
24 Aid shall file with the Joint Committee on Administrative
25 Rules, pursuant to the Illinois Administrative Procedure Act, a
26 proposed rule, or a proposed amendment to an existing rule,

1 regarding payment for appropriate services, including
2 assessment, care planning, discharge planning, and treatment
3 provided by nursing facilities to residents who have a serious
4 mental illness.

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

10 (Source: P.A. 95-331, eff. 8-21-07; 96-1123, eff. 1-1-11;
11 96-1530, eff. 2-16-11.)

12 (305 ILCS 5/5-5.8b) (from Ch. 23, par. 5-5.8b)

13 Sec. 5-5.8b. Payment to Campus Facilities. There is hereby
14 established a separate payment category for campus facilities.
15 A "campus facility" is defined as an entity which consists of a
16 long term care facility (or group of facilities if the
17 facilities are on the same contiguous parcel of real estate)
18 which meets all of the following criteria as of May 1, 1987:
19 the entity provides care for both children and adults;
20 residents of the entity reside in three or more separate
21 buildings with congregate and small group living arrangements
22 on a single campus; the entity provides three or more separate
23 licensed levels of care; the entity (or a part of the entity)
24 is enrolled with the Department of Healthcare and Family
25 Services as a provider of long term care services and receives

1 payments from that Department; the entity (or a part of the
2 entity) receives funding from the Department of Human Services;
3 and the entity (or a part of the entity) holds a current
4 license as a child care institution issued by the Department of
5 Children and Family Services.

6 The Department of Healthcare and Family Services, the
7 Department of Human Services, and the Department of Children
8 and Family Services shall develop jointly a rate methodology or
9 methodologies for campus facilities. Such methodology or
10 methodologies may establish a single rate to be paid by all the
11 agencies, or a separate rate to be paid by each agency, or
12 separate components to be paid to different parts of the campus
13 facility. All campus facilities shall receive the same rate of
14 payment for similar services. Any methodology developed
15 pursuant to this section shall take into account the actual
16 costs to the facility of providing services to residents, and
17 shall be adequate to reimburse the allowable costs of a campus
18 facility which is economically and efficiently operated. Any
19 methodology shall be established on the basis of historical,
20 financial, and statistical data submitted by campus
21 facilities, and shall take into account the actual costs
22 incurred by campus facilities in providing services, and in
23 meeting licensing and certification standards imposed and
24 prescribed by the State of Illinois, any of its political
25 subdivisions or municipalities and by the United States
26 Department of Health and Human Services. Rates may be

1 established on a prospective or retrospective basis. Any
2 methodology shall provide reimbursement for appropriate
3 payment elements, including the following: standard services,
4 patient services, real estate taxes, and capital costs.

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

10 (Source: P.A. 95-331, eff. 8-21-07; 96-1530, eff. 2-16-11.)

11 (305 ILCS 5/5-5.12) (from Ch. 23, par. 5-5.12)

12 Sec. 5-5.12. Pharmacy payments.

13 (a) Every request submitted by a pharmacy for reimbursement
14 under this Article for prescription drugs provided to a
15 recipient of aid under this Article shall include the name of
16 the prescriber or an acceptable identification number as
17 established by the Department.

18 (b) Pharmacies providing prescription drugs under this
19 Article shall be reimbursed at a rate which shall include a
20 professional dispensing fee as determined by the Illinois
21 Department, plus the current acquisition cost of the
22 prescription drug dispensed. The Illinois Department shall
23 update its information on the acquisition costs of all
24 prescription drugs no less frequently than every 30 days.
25 However, the Illinois Department may set the rate of

1 reimbursement for the acquisition cost, by rule, at a
2 percentage of the current average wholesale acquisition cost.

3 (c) (Blank).

4 ~~(d) The Department shall not impose requirements for prior~~
5 ~~approval based on a preferred drug list for anti retroviral,~~
6 ~~anti hemophilic factor concentrates, or any atypical~~
7 ~~antipsychotics, conventional antipsychotics, or~~
8 ~~anticonvulsants used for the treatment of serious mental~~
9 ~~illnesses until 30 days after it has conducted a study of the~~
10 ~~impact of such requirements on patient care and submitted a~~
11 ~~report to the Speaker of the House of Representatives and the~~
12 ~~President of the Senate.~~ The Department shall review
13 utilization of narcotic medications in the medical assistance
14 program and impose utilization controls that protect against
15 abuse.

16 (e) When making determinations as to which drugs shall be
17 on a prior approval list, the Department shall include as part
18 of the analysis for this determination, the degree to which a
19 drug may affect individuals in different ways based on factors
20 including the gender of the person taking the medication.

21 (f) The Department shall cooperate with the Department of
22 Public Health and the Department of Human Services Division of
23 Mental Health in identifying psychotropic medications that,
24 when given in a particular form, manner, duration, or frequency
25 (including "as needed") in a dosage, or in conjunction with
26 other psychotropic medications to a nursing home resident or to

1 a resident of a facility licensed under the ID/DD ~~MR/DD~~
2 Community Care Act, may constitute a chemical restraint or an
3 "unnecessary drug" as defined by the Nursing Home Care Act or
4 Titles XVIII and XIX of the Social Security Act and the
5 implementing rules and regulations. The Department shall
6 require prior approval for any such medication prescribed for a
7 nursing home resident or to a resident of a facility licensed
8 under the ID/DD ~~MR/DD~~ Community Care Act, that appears to be a
9 chemical restraint or an unnecessary drug. The Department shall
10 consult with the Department of Human Services Division of
11 Mental Health in developing a protocol and criteria for
12 deciding whether to grant such prior approval.

13 (g) The Department may by rule provide for reimbursement of
14 the dispensing of a 90-day supply of a generic or brand name,
15 non-narcotic maintenance medication in circumstances where it
16 is cost effective.

17 (g-5) On and after July 1, 2012, the Department may require
18 the dispensing of drugs to nursing home residents be in a 7-day
19 supply or other amount less than a 31-day supply. The
20 Department shall pay only one dispensing fee per 31-day supply.

21 (h) Effective July 1, 2011, the Department shall
22 discontinue coverage of select over-the-counter drugs,
23 including analgesics and cough and cold and allergy
24 medications.

25 (h-5) On and after July 1, 2012, the Department shall
26 impose utilization controls, including, but not limited to,

1 prior approval on specialty drugs, oncolytic drugs, drugs for
2 the treatment of HIV or AIDS, immunosuppressant drugs, and
3 biological products in order to maximize savings on these
4 drugs. The Department may adjust payment methodologies for
5 non-pharmacy billed drugs in order to incentivize the selection
6 of lower-cost drugs. For drugs for the treatment of AIDS, the
7 Department shall take into consideration the potential for
8 non-adherence by certain populations, and shall develop
9 protocols with organizations or providers primarily serving
10 those with HIV/AIDS, as long as such measures intend to
11 maintain cost neutrality with other utilization management
12 controls such as prior approval. For hemophilia, the Department
13 shall develop a program of utilization review and control which
14 may include, in the discretion of the Department, prior
15 approvals. The Department may impose special standards on
16 providers that dispense blood factors which shall include, in
17 the discretion of the Department, staff training and education;
18 patient outreach and education; case management; in-home
19 patient assessments; assay management; maintenance of stock;
20 emergency dispensing timeframes; data collection and
21 reporting; dispensing of supplies related to blood factor
22 infusions; cold chain management and packaging practices; care
23 coordination; product recalls; and emergency clinical
24 consultation. The Department may require patients to receive a
25 comprehensive examination annually at an appropriate provider
26 in order to be eligible to continue to receive blood factor.

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

6 (i) (Blank). ~~The Department shall seek any necessary waiver~~
7 ~~from the federal government in order to establish a program~~
8 ~~limiting the pharmacies eligible to dispense specialty drugs~~
9 ~~and shall issue a Request for Proposals in order to maximize~~
10 ~~savings on these drugs. The Department shall by rule establish~~
11 ~~the drugs required to be dispensed in this program.~~

12 (j) On and after July 1, 2012, the Department shall impose
13 limitations on prescription drugs such that the Department
14 shall not provide reimbursement for more than 4 prescriptions,
15 including 3 brand name prescriptions, for distinct drugs in a
16 30-day period, unless prior approval is received for all
17 prescriptions in excess of the 4-prescription limit. Drugs in
18 the following therapeutic classes shall not be subject to prior
19 approval as a result of the 4-prescription limit:
20 immunosuppressant drugs, oncolytic drugs, and anti-retroviral
21 drugs.

22 (k) No medication therapy management program implemented
23 by the Department shall be contrary to the provisions of the
24 Pharmacy Practice Act.

25 (l) Any provider enrolled with the Department that bills
26 the Department for outpatient drugs and is eligible to enroll

1 in the federal Drug Pricing Program under Section 340B of the
2 federal Public Health Services Act shall enroll in that
3 program. No entity participating in the federal Drug Pricing
4 Program under Section 340B of the federal Public Health
5 Services Act may exclude Medicaid from their participation in
6 that program.

7 (Source: P.A. 96-1269, eff. 7-26-10; 96-1372, eff. 7-29-10;
8 96-1501, eff. 1-25-11; 97-38, eff. 6-28-11; 97-74, eff.
9 6-30-11; 97-333, eff. 8-12-11; 97-426, eff. 1-1-12; revised
10 10-4-11.)

11 (305 ILCS 5/5-5.17) (from Ch. 23, par. 5-5.17)

12 Sec. 5-5.17. Separate reimbursement rate. The Illinois
13 Department may by rule establish a separate reimbursement rate
14 to be paid to long term care facilities for adult developmental
15 training services as defined in Section 15.2 of the Mental
16 Health and Developmental Disabilities Administrative Act which
17 are provided to intellectually disabled residents of such
18 facilities who receive aid under this Article. Any such
19 reimbursement shall be based upon cost reports submitted by the
20 providers of such services and shall be paid by the long term
21 care facility to the provider within such time as the Illinois
22 Department shall prescribe by rule, but in no case less than 3
23 business days after receipt of the reimbursement by such
24 facility from the Illinois Department. The Illinois Department
25 may impose a penalty upon a facility which does not make

1 payment to the provider of adult developmental training
2 services within the time so prescribed, up to the amount of
3 payment not made to the provider.

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

9 (Source: P.A. 97-227, eff. 1-1-12.)

10 (305 ILCS 5/5-5.20)

11 Sec. 5-5.20. Clinic payments. For services provided by
12 federally qualified health centers as defined in Section 1905
13 (1) (2) (B) of the federal Social Security Act, on or after April
14 1, 1989, and as long as required by federal law, the Illinois
15 Department shall reimburse those health centers for those
16 services according to a prospective cost-reimbursement
17 methodology.

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

23 (Source: P.A. 89-38, eff. 1-1-96.)

24 (305 ILCS 5/5-5.23)

1 Sec. 5-5.23. Children's mental health services.

2 (a) The Department of Healthcare and Family Services, by
3 rule, shall require the screening and assessment of a child
4 prior to any Medicaid-funded admission to an inpatient hospital
5 for psychiatric services to be funded by Medicaid. The
6 screening and assessment shall include a determination of the
7 appropriateness and availability of out-patient support
8 services for necessary treatment. The Department, by rule,
9 shall establish methods and standards of payment for the
10 screening, assessment, and necessary alternative support
11 services.

12 (b) The Department of Healthcare and Family Services, to
13 the extent allowable under federal law, shall secure federal
14 financial participation for Individual Care Grant expenditures
15 made by the Department of Human Services for the Medicaid
16 optional service authorized under Section 1905(h) of the
17 federal Social Security Act, pursuant to the provisions of
18 Section 7.1 of the Mental Health and Developmental Disabilities
19 Administrative Act.

20 (c) The Department of Healthcare and Family Services shall
21 work jointly with the Department of Human Services to implement
22 subsections (a) and (b).

23 (d) On and after July 1, 2012, the Department shall reduce
24 any rate of reimbursement for services or other payments or
25 alter any methodologies authorized by this Code to reduce any
26 rate of reimbursement for services or other payments in

1 accordance with Section 5-5e.

2 (Source: P.A. 95-331, eff. 8-21-07.)

3 (305 ILCS 5/5-5.24)

4 Sec. 5-5.24. Prenatal and perinatal care. The Department of
5 Healthcare and Family Services may provide reimbursement under
6 this Article for all prenatal and perinatal health care
7 services that are provided for the purpose of preventing
8 low-birthweight infants, reducing the need for neonatal
9 intensive care hospital services, and promoting perinatal
10 health. These services may include comprehensive risk
11 assessments for pregnant women, women with infants, and
12 infants, lactation counseling, nutrition counseling,
13 childbirth support, psychosocial counseling, treatment and
14 prevention of periodontal disease, and other support services
15 that have been proven to improve birth outcomes. The Department
16 shall maximize the use of preventive prenatal and perinatal
17 health care services consistent with federal statutes, rules,
18 and regulations. The Department of Public Aid (now Department
19 of Healthcare and Family Services) shall develop a plan for
20 prenatal and perinatal preventive health care and shall present
21 the plan to the General Assembly by January 1, 2004. On or
22 before January 1, 2006 and every 2 years thereafter, the
23 Department shall report to the General Assembly concerning the
24 effectiveness of prenatal and perinatal health care services
25 reimbursed under this Section in preventing low-birthweight

1 infants and reducing the need for neonatal intensive care
2 hospital services. Each such report shall include an evaluation
3 of how the ratio of expenditures for treating low-birthweight
4 infants compared with the investment in promoting healthy
5 births and infants in local community areas throughout Illinois
6 relates to healthy infant development in those areas.

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

12 (Source: P.A. 95-331, eff. 8-21-07.)

13 (305 ILCS 5/5-5.25)

14 Sec. 5-5.25. Access to psychiatric mental health services.
15 The General Assembly finds that providing access to psychiatric
16 mental health services in a timely manner will improve the
17 quality of life for persons suffering from mental illness and
18 will contain health care costs by avoiding the need for more
19 costly inpatient hospitalization. The Department of Healthcare
20 and Family Services shall reimburse psychiatrists and
21 federally qualified health centers as defined in Section
22 1905(1)(2)(B) of the federal Social Security Act for mental
23 health services provided by psychiatrists, as authorized by
24 Illinois law, to recipients via telepsychiatry. The
25 Department, by rule, shall establish (i) criteria for such

1 services to be reimbursed, including appropriate facilities
2 and equipment to be used at both sites and requirements for a
3 physician or other licensed health care professional to be
4 present at the site where the patient is located, and (ii) a
5 method to reimburse providers for mental health services
6 provided by telepsychiatry.

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

12 (Source: P.A. 95-16, eff. 7-18-07.)

13 (305 ILCS 5/5-5e new)

14 Sec. 5-5e. Adjusted rates of reimbursement.

15 (a) Rates or payments for services in effect on June 30,
16 2012 shall be adjusted and services shall be affected as
17 required by any other provision of this amendatory Act of the
18 97th General Assembly. In addition, the Department shall do the
19 following:

20 (1) Delink the per diem rate paid for supportive living
21 facility services from the per diem rate paid for nursing
22 facility services, effective for services provided on or
23 after May 1, 2011.

24 (2) Cease payment for bed reserves in nursing
25 facilities, specialized mental health rehabilitation

1 facilities, and, except in the instance of residents who
2 are under 21 years of age, intermediate care facilities for
3 persons with developmental disabilities.

4 (3) Cease payment of the \$10 per day add-on payment to
5 nursing facilities for certain residents with
6 developmental disabilities.

7 (b) After the application of subsection (a),
8 notwithstanding any other provision of this Code to the
9 contrary and to the extent permitted by federal law, on and
10 after July 1, 2012, the rates of reimbursement for services and
11 other payments provided under this Code shall further be
12 reduced as follows:

13 (1) Rates or payments for physician services, dental
14 services, or community health center services reimbursed
15 through an encounter rate, and services provided under the
16 Medicaid Rehabilitation Option of the Illinois Title XIX
17 State Plan shall not be further reduced.

18 (2) Rates or payments, or the portion thereof, paid to
19 a provider that is operated by a unit of local government
20 or State University that provides the non-federal share of
21 such services shall not be further reduced.

22 (3) Rates or payments for hospital services delivered
23 by a hospital defined as a Safety-Net Hospital under
24 Section 5-5e.1 of this Code shall not be further reduced.

25 (4) Rates or payments for hospital services delivered
26 by a Critical Access Hospital, which is an Illinois

1 hospital designated as a critical care hospital by the
2 Department of Public Health in accordance with 42 CFR 485,
3 Subpart F, shall not be further reduced.

4 (5) Rates or payments for Nursing Facility Services
5 shall only be further adjusted pursuant to Section 5-5.2 of
6 this Code.

7 (6) Rates or payments for services delivered by long
8 term care facilities licensed under the ID/DD Community
9 Care Act and developmental training services shall not be
10 further reduced.

11 (7) Rates or payments for services provided under
12 capitation rates shall be adjusted taking into
13 consideration the rates reduction and covered services
14 required by this amendatory Act of the 97th General
15 Assembly.

16 (8) For hospitals not previously described in this
17 subsection, the rates or payments for hospital services
18 shall be further reduced by 3.5%.

19 (9) For all other rates or payments for services
20 delivered by providers not specifically referenced in
21 paragraphs (1) through (8), rates or payments shall be
22 further reduced by 2.7%.

23 (c) Any assessment imposed by this Code shall continue and
24 nothing in this Section shall be construed to cause it to
25 cease.

1 (305 ILCS 5/5-5e.1 new)

2 Sec. 5-5e.1. Safety-Net Hospitals.

3 (a) A Safety-Net Hospital is an Illinois hospital that:

4 (1) is licensed by the Department of Public Health as a
5 general acute care or pediatric hospital; and

6 (2) does not operate for profit; and

7 (3) is a disproportionate share hospital, as described
8 in Section 1923 of the federal Social Security Act, as
9 determined by the Department; and

10 (4) meets one of the following:

11 (A) has a MIUR of at least 40% and a charity
12 percent of at least 4%; or

13 (B) has a MIUR of at least 50%.

14 (b) Definitions. As used in this Section:

15 (1) "Charity percent" means the ratio of (i) the
16 hospital's charity charges for services provided to
17 individuals without health insurance or another source of
18 third party coverage to (ii) the Illinois total hospital
19 charges, each as reported on the hospital's OBRA form.

20 (2) "MIUR" means Medicaid Inpatient Utilization Rate
21 and is defined as a fraction, the numerator of which is the
22 number of a hospital's inpatient days provided in the
23 hospital's fiscal year ending 3 years prior to the rate
24 year, to patients who, for such days, were eligible for
25 Medicaid under Title XIX of the federal Social Security
26 Act, 42 USC 1396a et seq., and the denominator of which is

1 the total number of the hospital's inpatient days in that
2 same period.

3 (3) "OBRA form" means form HFS-3834, OBRA '93 data
4 collection form, for the rate year.

5 (4) "Rate year" means the 12-month period beginning on
6 October 1.

7 (c) For the 15-month period beginning July 1, 2012, a
8 hospital that would have qualified for the rate year beginning
9 October 1, 2011, shall be a Safety-Net Hospital.

10 (d) No later than August 15 preceding the rate year, each
11 hospital shall submit the OBRA form to the Department. Prior to
12 October 1, the Department shall notify each hospital whether it
13 has qualified as a Safety-Net Hospital.

14 (e) The Department may promulgate rules in order to
15 implement this Section.

16 (305 ILCS 5/5-5f new)

17 Sec. 5-5f. Elimination and limitations of medical
18 assistance services. Notwithstanding any other provision of
19 this Code to the contrary, on and after July 1, 2012:

20 (a) The following services shall no longer be a covered
21 service available under this Code: group psychotherapy for
22 residents of any facility licensed under the Nursing Home Care
23 Act or the Specialized Mental Health Rehabilitation Act; adult
24 chiropractic services; and adult inpatient detoxification
25 services in hospitals.

1 (b) The Department shall place the following limitations on
2 services: (i) the Department shall limit adult eyeglasses to
3 one pair every 2 years; (ii) the Department shall set an annual
4 limit of a maximum of 20 visits for each of the following
5 services: adult speech, hearing, and language therapy
6 services, adult occupational therapy services, and physical
7 therapy services; (iii) the Department shall limit podiatry
8 services to individuals with diabetes; (iv) the Department
9 shall pay for caesarean sections at the normal vaginal delivery
10 rate unless a caesarean section was medically necessary; and
11 (v) the Department shall limit adult dental services to
12 emergencies.

13 (c) The Department shall require prior approval of the
14 following services: wheelchair repairs, regardless of the cost
15 of the repairs, coronary artery bypass graft, and bariatric
16 surgery consistent with Medicare standards concerning patient
17 responsibility. The wholesale cost of power wheelchairs shall
18 be actual acquisition cost including all discounts.

19 (d) The Department shall establish benchmarks for
20 hospitals to measure and align payments to reduce potentially
21 preventable hospital readmissions, inpatient complications,
22 and unnecessary emergency room visits. In doing so, the
23 Department shall consider items, including, but not limited to,
24 historic and current acuity of care and historic and current
25 trends in readmission. The Department shall publish
26 provider-specific historical readmission data and anticipated

1 potentially preventable targets 60 days prior to the start of
2 the program. In the instance of readmissions, the Department
3 shall adopt policies and rates of reimbursement for services
4 and other payments provided under this Code to ensure that, by
5 June 30, 2013, expenditures to hospitals are reduced by, at a
6 minimum, \$40,000,000.

7 (e) The Department shall establish utilization controls
8 for the hospice program such that it shall not pay for other
9 care services when an individual is in hospice.

10 (f) For home health services, the Department shall require
11 Medicare certification of providers participating in the
12 program, implement the Medicare face-to-face encounter rule,
13 and limit services to post-hospitalization. The Department
14 shall require providers to implement auditable electronic
15 service verification based on global positioning systems or
16 other cost-effective technology.

17 (g) For the Home Services Program operated by the
18 Department of Human Services and the Community Care Program
19 operated by the Department on Aging, the Department of Human
20 Services, in cooperation with the Department on Aging, shall
21 implement an electronic service verification based on global
22 positioning systems or other cost-effective technology.

23 (h) The Department shall not pay for hospital admissions
24 when the claim indicates a hospital acquired condition that
25 would cause Medicare to reduce its payment on the claim had the
26 claim been submitted to Medicare, nor shall the Department pay

1 for hospital admissions where a Medicare identified "never
2 event" occurred.

3 (i) The Department shall implement cost savings
4 initiatives for advanced imaging services, cardiac imaging
5 services, pain management services, and back surgery. Such
6 initiatives shall be designed to achieve annual costs savings.

7 (305 ILCS 5/5-16.7)

8 Sec. 5-16.7. Post-parturition care. The medical assistance
9 program shall provide the post-parturition care benefits
10 required to be covered by a policy of accident and health
11 insurance under Section 356s of the Illinois Insurance Code.

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

17 (Source: P.A. 89-513, eff. 9-15-96; 90-14, eff. 7-1-97.)

18 (305 ILCS 5/5-16.7a)

19 Sec. 5-16.7a. Reimbursement for epidural anesthesia
20 services. In addition to other procedures authorized by the
21 Department under this Code, the Department shall provide
22 reimbursement to medical providers for epidural anesthesia
23 services when ordered by the attending practitioner at the time
24 of delivery.

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

6 (Source: P.A. 93-981, eff. 8-23-04.)

7 (305 ILCS 5/5-16.8)

8 Sec. 5-16.8. Required health benefits. The medical
9 assistance program shall (i) provide the post-mastectomy care
10 benefits required to be covered by a policy of accident and
11 health insurance under Section 356t and the coverage required
12 under Sections 356g.5, 356u, 356w, 356x, and 356z.6 of the
13 Illinois Insurance Code and (ii) be subject to the provisions
14 of Sections 356z.19 and 364.01 of the Illinois Insurance Code.

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

20 (Source: P.A. 97-282, eff. 8-9-11.)

21 (305 ILCS 5/5-16.9)

22 Sec. 5-16.9. Woman's health care provider. The medical
23 assistance program is subject to the provisions of Section 356r
24 of the Illinois Insurance Code. The Illinois Department shall

1 adopt rules to implement the requirements of Section 356r of
2 the Illinois Insurance Code in the medical assistance program
3 including managed care components.

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

9 (Source: P.A. 92-370, eff. 8-15-01.)

10 (305 ILCS 5/5-17) (from Ch. 23, par. 5-17)

11 Sec. 5-17. Programs to improve access to hospital care.

12 (a) (1) The General Assembly finds:

13 (A) That while hospitals have traditionally
14 provided charitable care to indigent patients, this
15 burden is not equally borne by all hospitals operating
16 in this State. Some hospitals continue to provide
17 significant amounts of care to low-income persons
18 while others provide very little such care; and

19 (B) That access to hospital care in this State by
20 the indigent citizens of Illinois would be seriously
21 impaired by the closing of hospitals that provide
22 significant amounts of care to low-income persons.

23 (2) To help expand the availability of hospital care
24 for all citizens of this State, it is the policy of the
25 State to implement programs that more equitably distribute

1 the burden of providing hospital care to Illinois'
2 low-income population and that improve access to health
3 care in Illinois.

4 (3) The Illinois Department may develop and implement a
5 program that lessens the burden of providing hospital care
6 to Illinois' low-income population, taking into account
7 the costs that must be incurred by hospitals providing
8 significant amounts of care to low-income persons, and may
9 develop adjustments to increase rates to improve access to
10 health care in Illinois. The Illinois Department shall
11 prescribe by rule the criteria, standards and procedures
12 for effecting such adjustments in the rates of hospital
13 payments for services provided to eligible low-income
14 persons (under Articles V, VI and VII of this Code) under
15 this Article.

16 (b) The Illinois Department shall require hospitals
17 certified to participate in the federal Medicaid program to:

18 (1) provide equal access to available services to
19 low-income persons who are eligible for assistance under
20 Articles V, VI and VII of this Code;

21 (2) provide data and reports on the provision of
22 uncompensated care.

23 (c) From the effective date of this amendatory Act of 1992
24 until July 1, 1992, nothing in this Section 5-17 shall be
25 construed as creating a private right of action on behalf of
26 any individual.

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

6 (Source: P.A. 87-13; 87-838.)

7 (305 ILCS 5/5-19) (from Ch. 23, par. 5-19)

8 Sec. 5-19. Healthy Kids Program.

9 (a) Any child under the age of 21 eligible to receive
10 Medical Assistance from the Illinois Department under Article V
11 of this Code shall be eligible for Early and Periodic
12 Screening, Diagnosis and Treatment services provided by the
13 Healthy Kids Program of the Illinois Department under the
14 Social Security Act, 42 U.S.C. 1396d(r).

15 (b) Enrollment of Children in Medicaid. The Illinois
16 Department shall provide for receipt and initial processing of
17 applications for Medical Assistance for all pregnant women and
18 children under the age of 21 at locations in addition to those
19 used for processing applications for cash assistance,
20 including disproportionate share hospitals, federally
21 qualified health centers and other sites as selected by the
22 Illinois Department.

23 (c) Healthy Kids Examinations. The Illinois Department
24 shall consider any examination of a child eligible for the
25 Healthy Kids services provided by a medical provider meeting

1 the requirements and complying with the rules and regulations
2 of the Illinois Department to be reimbursed as a Healthy Kids
3 examination.

4 (d) Medical Screening Examinations.

5 (1) The Illinois Department shall insure Medicaid
6 coverage for periodic health, vision, hearing, and dental
7 screenings for children eligible for Healthy Kids services
8 scheduled from a child's birth up until the child turns 21
9 years. The Illinois Department shall pay for vision,
10 hearing, dental and health screening examinations for any
11 child eligible for Healthy Kids services by qualified
12 providers at intervals established by Department rules.

13 (2) The Illinois Department shall pay for an
14 interperiodic health, vision, hearing, or dental screening
15 examination for any child eligible for Healthy Kids
16 services whenever an examination is:

17 (A) requested by a child's parent, guardian, or
18 custodian, or is determined to be necessary or
19 appropriate by social services, developmental, health,
20 or educational personnel; or

21 (B) necessary for enrollment in school; or

22 (C) necessary for enrollment in a licensed day care
23 program, including Head Start; or

24 (D) necessary for placement in a licensed child
25 welfare facility, including a foster home, group home
26 or child care institution; or

1 (E) necessary for attendance at a camping program;

2 or

3 (F) necessary for participation in an organized
4 athletic program; or

5 (G) necessary for enrollment in an early childhood
6 education program recognized by the Illinois State
7 Board of Education; or

8 (H) necessary for participation in a Women,
9 Infant, and Children (WIC) program; or

10 (I) deemed appropriate by the Illinois Department.

11 (e) Minimum Screening Protocols For Periodic Health
12 Screening Examinations. Health Screening Examinations must
13 include the following services:

14 (1) Comprehensive Health and Development Assessment
15 including:

16 (A) Development/Mental Health/Psychosocial
17 Assessment; and

18 (B) Assessment of nutritional status including
19 tests for iron deficiency and anemia for children at
20 the following ages: 9 months, 2 years, 8 years, and 18
21 years;

22 (2) Comprehensive unclothed physical exam;

23 (3) Appropriate immunizations at a minimum, as
24 required by the Secretary of the U.S. Department of Health
25 and Human Services under 42 U.S.C. 1396d(r).

26 (4) Appropriate laboratory tests including blood lead

1 levels appropriate for age and risk factors.

2 (A) Anemia test.

3 (B) Sickle cell test.

4 (C) Tuberculin test at 12 months of age and every
5 1-2 years thereafter unless the treating health care
6 professional determines that testing is medically
7 contraindicated.

8 (D) Other -- The Illinois Department shall insure
9 that testing for HIV, drug exposure, and sexually
10 transmitted diseases is provided for as clinically
11 indicated.

12 (5) Health Education. The Illinois Department shall
13 require providers to provide anticipatory guidance as
14 recommended by the American Academy of Pediatrics.

15 (6) Vision Screening. The Illinois Department shall
16 require providers to provide vision screenings consistent
17 with those set forth in the Department of Public Health's
18 Administrative Rules.

19 (7) Hearing Screening. The Illinois Department shall
20 require providers to provide hearing screenings consistent
21 with those set forth in the Department of Public Health's
22 Administrative Rules.

23 (8) Dental Screening. The Illinois Department shall
24 require providers to provide dental screenings consistent
25 with those set forth in the Department of Public Health's
26 Administrative Rules.

1 (f) Covered Medical Services. The Illinois Department
2 shall provide coverage for all necessary health care,
3 diagnostic services, treatment and other measures to correct or
4 ameliorate defects, physical and mental illnesses, and
5 conditions whether discovered by the screening services or not
6 for all children eligible for Medical Assistance under Article
7 V of this Code.

8 (g) Notice of Healthy Kids Services.

9 (1) The Illinois Department shall inform any child
10 eligible for Healthy Kids services and the child's family
11 about the benefits provided under the Healthy Kids Program,
12 including, but not limited to, the following: what services
13 are available under Healthy Kids, including discussion of
14 the periodicity schedules and immunization schedules, that
15 services are provided at no cost to eligible children, the
16 benefits of preventive health care, where the services are
17 available, how to obtain them, and that necessary
18 transportation and scheduling assistance is available.

19 (2) The Illinois Department shall widely disseminate
20 information regarding the availability of the Healthy Kids
21 Program throughout the State by outreach activities which
22 shall include, but not be limited to, (i) the development
23 of cooperation agreements with local school districts,
24 public health agencies, clinics, hospitals and other
25 health care providers, including developmental disability
26 and mental health providers, and with charities, to notify

1 the constituents of each of the Program and assist
2 individuals, as feasible, with applying for the Program,
3 (ii) using the media for public service announcements and
4 advertisements of the Program, and (iii) developing
5 posters advertising the Program for display in hospital and
6 clinic waiting rooms.

7 (3) The Illinois Department shall utilize accepted
8 methods for informing persons who are illiterate, blind,
9 deaf, or cannot understand the English language, including
10 but not limited to public services announcements and
11 advertisements in the foreign language media of radio,
12 television and newspapers.

13 (4) The Illinois Department shall provide notice of the
14 Healthy Kids Program to every child eligible for Healthy
15 Kids services and his or her family at the following times:

16 (A) orally by the intake worker and in writing at
17 the time of application for Medical Assistance;

18 (B) at the time the applicant is informed that he
19 or she is eligible for Medical Assistance benefits; and

20 (C) at least 20 days before the date of any
21 periodic health, vision, hearing, and dental
22 examination for any child eligible for Healthy Kids
23 services. Notice given under this subparagraph (C)
24 must state that a screening examination is due under
25 the periodicity schedules and must advise the eligible
26 child and his or her family that the Illinois

1 Department will provide assistance in scheduling an
2 appointment and arranging medical transportation.

3 (h) Data Collection. The Illinois Department shall collect
4 data in a usable form to track utilization of Healthy Kids
5 screening examinations by children eligible for Healthy Kids
6 services, including but not limited to data showing screening
7 examinations and immunizations received, a summary of
8 follow-up treatment received by children eligible for Healthy
9 Kids services and the number of children receiving dental,
10 hearing and vision services.

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

16 (Source: P.A. 87-630; 87-895.)

17 (305 ILCS 5/5-24)

18 (Section scheduled to be repealed on January 1, 2014)

19 Sec. 5-24. Disease management programs and services for
20 chronic conditions; pilot project.

21 (a) In this Section, "disease management programs and
22 services" means services administered to patients in order to
23 improve their overall health and to prevent clinical
24 exacerbations and complications, using cost-effective,
25 evidence-based practice guidelines and patient self-management

1 strategies. Disease management programs and services include
2 all of the following:

3 (1) A population identification process.

4 (2) Evidence-based or consensus-based clinical
5 practice guidelines, risk identification, and matching of
6 interventions with clinical need.

7 (3) Patient self-management and disease education.

8 (4) Process and outcomes measurement, evaluation,
9 management, and reporting.

10 (b) Subject to appropriations, the Department of
11 Healthcare and Family Services may undertake a pilot project to
12 study patient outcomes, for patients with chronic diseases or
13 patients at risk of low birth weight or premature birth,
14 associated with the use of disease management programs and
15 services for chronic condition management. "Chronic diseases"
16 include, but are not limited to, diabetes, congestive heart
17 failure, and chronic obstructive pulmonary disease. Low birth
18 weight and premature birth include all medical and other
19 conditions that lead to poor birth outcomes or problematic
20 pregnancies.

21 (c) The disease management programs and services pilot
22 project shall examine whether chronic disease management
23 programs and services for patients with specific chronic
24 conditions do any or all of the following:

25 (1) Improve the patient's overall health in a more
26 expeditious manner.

1 (2) Lower costs in other aspects of the medical
2 assistance program, such as hospital admissions, days in
3 skilled nursing homes, emergency room visits, or more
4 frequent physician office visits.

5 (d) In carrying out the pilot project, the Department of
6 Healthcare and Family Services shall examine all relevant
7 scientific literature and shall consult with health care
8 practitioners including, but not limited to, physicians,
9 surgeons, registered pharmacists, and registered nurses.

10 (e) The Department of Healthcare and Family Services shall
11 consult with medical experts, disease advocacy groups, and
12 academic institutions to develop criteria to be used in
13 selecting a vendor for the pilot project.

14 (f) The Department of Healthcare and Family Services may
15 adopt rules to implement this Section.

16 (g) This Section is repealed 10 years after the effective
17 date of this amendatory Act of the 93rd General Assembly.

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

23 (Source: P.A. 95-331, eff. 8-21-07; 96-799, eff. 10-28-09.)

24 (305 ILCS 5/5-30)

25 Sec. 5-30. Care coordination.

1 (a) At least 50% of recipients eligible for comprehensive
2 medical benefits in all medical assistance programs or other
3 health benefit programs administered by the Department,
4 including the Children's Health Insurance Program Act and the
5 Covering ALL KIDS Health Insurance Act, shall be enrolled in a
6 care coordination program by no later than January 1, 2015. For
7 purposes of this Section, "coordinated care" or "care
8 coordination" means delivery systems where recipients will
9 receive their care from providers who participate under
10 contract in integrated delivery systems that are responsible
11 for providing or arranging the majority of care, including
12 primary care physician services, referrals from primary care
13 physicians, diagnostic and treatment services, behavioral
14 health services, in-patient and outpatient hospital services,
15 dental services, and rehabilitation and long-term care
16 services. The Department shall designate or contract for such
17 integrated delivery systems (i) to ensure enrollees have a
18 choice of systems and of primary care providers within such
19 systems; (ii) to ensure that enrollees receive quality care in
20 a culturally and linguistically appropriate manner; and (iii)
21 to ensure that coordinated care programs meet the diverse needs
22 of enrollees with developmental, mental health, physical, and
23 age-related disabilities.

24 (b) Payment for such coordinated care shall be based on
25 arrangements where the State pays for performance related to
26 health care outcomes, the use of evidence-based practices, the

1 use of primary care delivered through comprehensive medical
2 homes, the use of electronic medical records, and the
3 appropriate exchange of health information electronically made
4 either on a capitated basis in which a fixed monthly premium
5 per recipient is paid and full financial risk is assumed for
6 the delivery of services, or through other risk-based payment
7 arrangements.

8 (c) To qualify for compliance with this Section, the 50%
9 goal shall be achieved by enrolling medical assistance
10 enrollees from each medical assistance enrollment category,
11 including parents, children, seniors, and people with
12 disabilities to the extent that current State Medicaid payment
13 laws would not limit federal matching funds for recipients in
14 care coordination programs. In addition, services must be more
15 comprehensively defined and more risk shall be assumed than in
16 the Department's primary care case management program as of the
17 effective date of this amendatory Act of the 96th General
18 Assembly.

19 (d) The Department shall report to the General Assembly in
20 a separate part of its annual medical assistance program
21 report, beginning April, 2012 until April, 2016, on the
22 progress and implementation of the care coordination program
23 initiatives established by the provisions of this amendatory
24 Act of the 96th General Assembly. The Department shall include
25 in its April 2011 report a full analysis of federal laws or
26 regulations regarding upper payment limitations to providers

1 and the necessary revisions or adjustments in rate
2 methodologies and payments to providers under this Code that
3 would be necessary to implement coordinated care with full
4 financial risk by a party other than the Department.

5 (e) Integrated Care Program for individuals with chronic
6 mental health conditions.

7 (1) The Integrated Care Program shall encompass
8 services administered to recipients of medical assistance
9 under this Article to prevent exacerbations and
10 complications using cost-effective, evidence-based
11 practice guidelines and mental health management
12 strategies.

13 (2) The Department may utilize and expand upon existing
14 contractual arrangements with integrated care plans under
15 the Integrated Care Program for providing the coordinated
16 care provisions of this Section.

17 (3) Payment for such coordinated care shall be based on
18 arrangements where the State pays for performance related
19 to mental health outcomes on a capitated basis in which a
20 fixed monthly premium per recipient is paid and full
21 financial risk is assumed for the delivery of services, or
22 through other risk-based payment arrangements such as
23 provider-based care coordination.

24 (4) The Department shall examine whether chronic
25 mental health management programs and services for
26 recipients with specific chronic mental health conditions

1 do any or all of the following:

2 (A) Improve the patient's overall mental health in
3 a more expeditious and cost-effective manner.

4 (B) Lower costs in other aspects of the medical
5 assistance program, such as hospital admissions,
6 emergency room visits, or more frequent and
7 inappropriate psychotropic drug use.

8 (5) The Department shall work with the facilities and
9 any integrated care plan participating in the program to
10 identify and correct barriers to the successful
11 implementation of this subsection (e) prior to and during
12 the implementation to best facilitate the goals and
13 objectives of this subsection (e).

14 (f) A hospital that is located in a county of the State in
15 which the Department mandates some or all of the beneficiaries
16 of the Medical Assistance Program residing in the county to
17 enroll in a Care Coordination Program, as set forth in Section
18 5-30 of this Code, shall not be eligible for any non-claims
19 based payments not mandated by Article V-A of this Code for
20 which it would otherwise be qualified to receive, unless the
21 hospital is a Coordinated Care Participating Hospital no later
22 that 60 days after the effective date of this amendatory Act of
23 the 97th General assembly or 60 days after the first mandatory
24 enrollment of a beneficiary in a Coordinated Care program. For
25 purposes of this subsection, "Coordinated Care Participating
26 Hospital" means a hospital that meets one of the following

1 criteria:

2 (1) The hospital has entered into a contract to provide
3 hospital services to enrollees of the care coordination
4 program.

5 (2) The hospital has not been offered a contract by a
6 care coordination plan that pays at least as much as the
7 Department would pay, on a fee-for-service-basis, not
8 including disproportionate share hospital adjustment
9 payments or any other supplemental adjustment or add-on
10 payment to the base fee-for-service rate.

11 (Source: P.A. 96-1501, eff. 1-25-11.)

12 (305 ILCS 5/5A-1) (from Ch. 23, par. 5A-1)

13 Sec. 5A-1. Definitions. As used in this Article, unless
14 the context requires otherwise:

15 ~~"Adjusted gross hospital revenue" shall be determined~~
16 ~~separately for inpatient and outpatient services for each~~
17 ~~hospital conducted, operated or maintained by a hospital~~
18 ~~provider, and means the hospital provider's total gross~~
19 ~~revenues less: (i) gross revenue attributable to non-hospital~~
20 ~~based services including home dialysis services, durable~~
21 ~~medical equipment, ambulance services, outpatient clinics and~~
22 ~~any other non-hospital based services as determined by the~~
23 ~~Illinois Department by rule; and (ii) gross revenues~~
24 ~~attributable to the routine services provided to persons~~
25 ~~receiving skilled or intermediate long term care services~~

1 ~~within the meaning of Title XVIII or XIX of the Social Security~~
2 ~~Act; and (iii) Medicare gross revenue (excluding the Medicare~~
3 ~~gross revenue attributable to clauses (i) and (ii) of this~~
4 ~~paragraph and the Medicare gross revenue attributable to the~~
5 ~~routine services provided to patients in a psychiatric~~
6 ~~hospital, a rehabilitation hospital, a distinct part~~
7 ~~psychiatric unit, a distinct part rehabilitation unit, or swing~~
8 ~~beds). Adjusted gross hospital revenue shall be determined~~
9 ~~using the most recent data available from each hospital's 2003~~
10 ~~Medicare cost report as contained in the Healthcare Cost Report~~
11 ~~Information System file, for the quarter ending on December 31,~~
12 ~~2004, without regard to any subsequent adjustments or changes~~
13 ~~to such data. If a hospital's 2003 Medicare cost report is not~~
14 ~~contained in the Healthcare Cost Report Information System, the~~
15 ~~hospital provider shall furnish such cost report or the data~~
16 ~~necessary to determine its adjusted gross hospital revenue as~~
17 ~~required by rule by the Illinois Department.~~

18 "Fund" means the Hospital Provider Fund.

19 "Hospital" means an institution, place, building, or
20 agency located in this State that is subject to licensure by
21 the Illinois Department of Public Health under the Hospital
22 Licensing Act, whether public or private and whether organized
23 for profit or not-for-profit.

24 "Hospital provider" means a person licensed by the
25 Department of Public Health to conduct, operate, or maintain a
26 hospital, regardless of whether the person is a Medicaid

1 provider. For purposes of this paragraph, "person" means any
2 political subdivision of the State, municipal corporation,
3 individual, firm, partnership, corporation, company, limited
4 liability company, association, joint stock association, or
5 trust, or a receiver, executor, trustee, guardian, or other
6 representative appointed by order of any court.

7 "Medicare bed days" means, for each hospital, the sum of
8 the number of days that each bed was occupied by a patient who
9 was covered by Title XVIII of the Social Security Act,
10 excluding days attributable to the routine services provided to
11 persons receiving skilled or intermediate long term care
12 services. Medicare bed days shall be computed separately for
13 each hospital operated or maintained by a hospital provider.

14 "Occupied bed days" means the sum of the number of days
15 that each bed was occupied by a patient for all beds, excluding
16 days attributable to the routine services provided to persons
17 receiving skilled or intermediate long term care services.
18 Occupied bed days shall be computed separately for each
19 hospital operated or maintained by a hospital provider.

20 ~~"Proration factor" means a fraction, the numerator of which~~
21 ~~is 53 and the denominator of which is 365.~~

22 (Source: P.A. 94-242, eff. 7-18-05; 95-859, eff. 8-19-08.)

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

24 (Section scheduled to be repealed on July 1, 2014)

25 Sec. 5A-2. Assessment.

1 ~~(a) Subject to Sections 5A-3 and 5A-10, an annual~~
2 ~~assessment on inpatient services is imposed on each hospital~~
3 ~~provider in an amount equal to the hospital's occupied bed days~~
4 ~~multiplied by \$84.19 multiplied by the proration factor for~~
5 ~~State fiscal year 2004 and the hospital's occupied bed days~~
6 ~~multiplied by \$84.19 for State fiscal year 2005.~~

7 ~~For State fiscal years 2004 and 2005, the Department of~~
8 ~~Healthcare and Family Services shall use the number of occupied~~
9 ~~bed days as reported by each hospital on the Annual Survey of~~
10 ~~Hospitals conducted by the Department of Public Health to~~
11 ~~calculate the hospital's annual assessment. If the sum of a~~
12 ~~hospital's occupied bed days is not reported on the Annual~~
13 ~~Survey of Hospitals or if there are data errors in the reported~~
14 ~~sum of a hospital's occupied bed days as determined by the~~
15 ~~Department of Healthcare and Family Services (formerly~~
16 ~~Department of Public Aid), then the Department of Healthcare~~
17 ~~and Family Services may obtain the sum of occupied bed days~~
18 ~~from any source available, including, but not limited to,~~
19 ~~records maintained by the hospital provider, which may be~~
20 ~~inspected at all times during business hours of the day by the~~
21 ~~Department of Healthcare and Family Services or its duly~~
22 ~~authorized agents and employees.~~

23 ~~Subject to Sections 5A-3 and 5A-10, for the privilege of~~
24 ~~engaging in the occupation of hospital provider, beginning~~
25 ~~August 1, 2005, an annual assessment is imposed on each~~
26 ~~hospital provider for State fiscal years 2006, 2007, and 2008,~~

1 ~~in an amount equal to 2.5835% of the hospital provider's~~
2 ~~adjusted gross hospital revenue for inpatient services and~~
3 ~~2.5835% of the hospital provider's adjusted gross hospital~~
4 ~~revenue for outpatient services. If the hospital provider's~~
5 ~~adjusted gross hospital revenue is not available, then the~~
6 ~~Illinois Department may obtain the hospital provider's~~
7 ~~adjusted gross hospital revenue from any source available,~~
8 ~~including, but not limited to, records maintained by the~~
9 ~~hospital provider, which may be inspected at all times during~~
10 ~~business hours of the day by the Illinois Department or its~~
11 ~~duly authorized agents and employees.~~

12 Subject to Sections 5A-3 and 5A-10, for State fiscal years
13 2009 through 2014 and July 1, 2014 through December 31, 2014,
14 an annual assessment on inpatient services is imposed on each
15 hospital provider in an amount equal to \$218.38 multiplied by
16 the difference of the hospital's occupied bed days less the
17 hospital's Medicare bed days.

18 For State fiscal years 2009 through 2014 and after, a
19 hospital's occupied bed days and Medicare bed days shall be
20 determined using the most recent data available from each
21 hospital's 2005 Medicare cost report as contained in the
22 Healthcare Cost Report Information System file, for the quarter
23 ending on December 31, 2006, without regard to any subsequent
24 adjustments or changes to such data. If a hospital's 2005
25 Medicare cost report is not contained in the Healthcare Cost
26 Report Information System, then the Illinois Department may

1 obtain the hospital provider's occupied bed days and Medicare
2 bed days from any source available, including, but not limited
3 to, records maintained by the hospital provider, which may be
4 inspected at all times during business hours of the day by the
5 Illinois Department or its duly authorized agents and
6 employees.

7 (b) (Blank).

8 (c) (Blank).

9 (d) Notwithstanding any of the other provisions of this
10 Section, the Department is authorized, ~~during this 94th General~~
11 ~~Assembly,~~ to adopt rules to reduce the rate of any annual
12 assessment imposed under this Section, as authorized by Section
13 5-46.2 of the Illinois Administrative Procedure Act.

14 (e) Notwithstanding any other provision of this Section,
15 any plan providing for an assessment on a hospital provider as
16 a permissible tax under Title XIX of the federal Social
17 Security Act and Medicaid-eligible payments to hospital
18 providers from the revenues derived from that assessment shall
19 be reviewed by the Illinois Department of Healthcare and Family
20 Services, as the Single State Medicaid Agency required by
21 federal law, to determine whether those assessments and
22 hospital provider payments meet federal Medicaid standards. If
23 the Department determines that the elements of the plan may
24 meet federal Medicaid standards and a related State Medicaid
25 Plan Amendment is prepared in a manner and form suitable for
26 submission, that State Plan Amendment shall be submitted in a

1 timely manner for review by the Centers for Medicare and
2 Medicaid Services of the United States Department of Health and
3 Human Services and subject to approval by the Centers for
4 Medicare and Medicaid Services of the United States Department
5 of Health and Human Services. No such plan shall become
6 effective without approval by the Illinois General Assembly by
7 the enactment into law of related legislation. Notwithstanding
8 any other provision of this Section, the Department is
9 authorized to adopt rules to reduce the rate of any annual
10 assessment imposed under this Section. Any such rules may be
11 adopted by the Department under Section 5-50 of the Illinois
12 Administrative Procedure Act.

13 (Source: P.A. 95-859, eff. 8-19-08; 96-1530, eff. 2-16-11.)

14 (305 ILCS 5/5A-3) (from Ch. 23, par. 5A-3)

15 Sec. 5A-3. Exemptions.

16 (a) (Blank).

17 (a-5) A hospital provider that is a county, township,
18 municipality, hospital district, or any other local
19 governmental unit is exempt from the assessment imposed by
20 Section 5A-2.

21 (b) A hospital provider that is a State agency or ~~or~~ a State
22 university, ~~or a county with a population of 3,000,000 or more~~
23 is exempt from the assessment imposed by Section 5A-2.

24 (b-2) (Blank). ~~A hospital provider that is a county with a~~
25 ~~population of less than 3,000,000 or a township, municipality,~~

1 ~~hospital district, or any other local governmental unit is~~
2 ~~exempt from the assessment imposed by Section 5A-2.~~

3 (b-5) (Blank).

4 (b-10) (Blank). ~~For State fiscal years 2004 through 2014, a~~
5 ~~hospital provider, described in Section 1903(w)(3)(F) of the~~
6 ~~Social Security Act, whose hospital does not charge for its~~
7 ~~services is exempt from the assessment imposed by Section 5A-2,~~
8 ~~unless the exemption is adjudged to be unconstitutional or~~
9 ~~otherwise invalid, in which case the hospital provider shall~~
10 ~~pay the assessment imposed by Section 5A-2.~~

11 (b-15) (Blank). ~~For State fiscal years 2004 and 2005, a~~
12 ~~hospital provider whose hospital is licensed by the Department~~
13 ~~of Public Health as a psychiatric hospital is exempt from the~~
14 ~~assessment imposed by Section 5A-2, unless the exemption is~~
15 ~~adjudged to be unconstitutional or otherwise invalid, in which~~
16 ~~case the hospital provider shall pay the assessment imposed by~~
17 ~~Section 5A-2.~~

18 (b-20) (Blank). ~~For State fiscal years 2004 and 2005, a~~
19 ~~hospital provider whose hospital is licensed by the Department~~
20 ~~of Public Health as a rehabilitation hospital is exempt from~~
21 ~~the assessment imposed by Section 5A-2, unless the exemption is~~
22 ~~adjudged to be unconstitutional or otherwise invalid, in which~~
23 ~~case the hospital provider shall pay the assessment imposed by~~
24 ~~Section 5A-2.~~

25 (b-25) (Blank). ~~For State fiscal years 2004 and 2005, a~~
26 ~~hospital provider whose hospital (i) is not a psychiatric~~

1 ~~hospital, rehabilitation hospital, or children's hospital and~~
2 ~~(ii) has an average length of inpatient stay greater than 25~~
3 ~~days is exempt from the assessment imposed by Section 5A-2,~~
4 ~~unless the exemption is adjudged to be unconstitutional or~~
5 ~~otherwise invalid, in which case the hospital provider shall~~
6 ~~pay the assessment imposed by Section 5A-2.~~

7 (c) (Blank).

8 (Source: P.A. 95-859, eff. 8-19-08; 96-1530, eff. 2-16-11.)

9 (305 ILCS 5/5A-4) (from Ch. 23, par. 5A-4)

10 Sec. 5A-4. Payment of assessment; penalty.

11 (a) The ~~The annual assessment imposed by Section 5A-2 for~~
12 ~~State fiscal year 2004 shall be due and payable on June 18 of~~
13 ~~the year. The assessment imposed by Section 5A-2 for State~~
14 ~~fiscal year 2005 shall be due and payable in quarterly~~
15 ~~installments, each equalling one fourth of the assessment for~~
16 ~~the year, on July 19, October 19, January 18, and April 19 of~~
17 ~~the year. The assessment imposed by Section 5A-2 for State~~
18 ~~fiscal years 2006 through 2008 shall be due and payable in~~
19 ~~quarterly installments, each equaling one fourth of the~~
20 ~~assessment for the year, on the fourteenth State business day~~
21 ~~of September, December, March, and May. Except as provided in~~
22 ~~subsection (a-5) of this Section, the assessment imposed by~~
23 Section 5A-2 for State fiscal year 2009 and each subsequent
24 State fiscal year shall be due and payable in monthly
25 installments, each equaling one-twelfth of the assessment for

1 the year, on the fourteenth State business day of each month.
2 No installment payment of an assessment imposed by Section 5A-2
3 shall be due and payable, however, until after the Comptroller
4 has issued the payments required under this Article. ~~:(i) the~~
5 ~~Department notifies the hospital provider, in writing, that the~~
6 ~~payment methodologies to hospitals required under Section~~
7 ~~5A 12, Section 5A 12.1, or Section 5A 12.2, whichever is~~
8 ~~applicable for that fiscal year, have been approved by the~~
9 ~~Centers for Medicare and Medicaid Services of the U.S.~~
10 ~~Department of Health and Human Services and the waiver under 42~~
11 ~~CFR 433.68 for the assessment imposed by Section 5A-2, if~~
12 ~~necessary, has been granted by the Centers for Medicare and~~
13 ~~Medicaid Services of the U.S. Department of Health and Human~~
14 ~~Services; and (ii) the Comptroller has issued the payments~~
15 ~~required under Section 5A 12, Section 5A 12.1, or Section~~
16 ~~5A 12.2, whichever is applicable for that fiscal year. Upon~~
17 ~~notification to the Department of approval of the payment~~
18 ~~methodologies required under Section 5A 12, Section 5A 12.1,~~
19 ~~or Section 5A 12.2, whichever is applicable for that fiscal~~
20 ~~year, and the waiver granted under 42 CFR 433.68, all~~
21 ~~installments otherwise due under Section 5A-2 prior to the date~~
22 ~~of notification shall be due and payable to the Department upon~~
23 ~~written direction from the Department and issuance by the~~
24 ~~Comptroller of the payments required under Section 5A 12.1 or~~
25 ~~Section 5A 12.2, whichever is applicable for that fiscal year.~~

26 (a-5) The Illinois Department may, for the purpose of

1 maximizing federal revenue, accelerate the schedule upon which
2 assessment installments are due and payable by hospitals with a
3 payment ratio greater than or equal to one. Such acceleration
4 of due dates for payment of the assessment may be made only in
5 conjunction with a corresponding acceleration in access
6 payments identified in Section 5A-12.2 to the same hospitals.
7 For the purposes of this subsection (a-5), a hospital's payment
8 ratio is defined as the quotient obtained by dividing the total
9 payments for the State fiscal year, as authorized under Section
10 5A-12.2, by the total assessment for the State fiscal year
11 imposed under Section 5A-2.

12 (b) The Illinois Department is authorized to establish
13 delayed payment schedules for hospital providers that are
14 unable to make installment payments when due under this Section
15 due to financial difficulties, as determined by the Illinois
16 Department.

17 (c) If a hospital provider fails to pay the full amount of
18 an installment when due (including any extensions granted under
19 subsection (b)), there shall, unless waived by the Illinois
20 Department for reasonable cause, be added to the assessment
21 imposed by Section 5A-2 a penalty assessment equal to the
22 lesser of (i) 5% of the amount of the installment not paid on
23 or before the due date plus 5% of the portion thereof remaining
24 unpaid on the last day of each 30-day period thereafter or (ii)
25 100% of the installment amount not paid on or before the due
26 date. For purposes of this subsection, payments will be

1 credited first to unpaid installment amounts (rather than to
2 penalty or interest), beginning with the most delinquent
3 installments.

4 (d) Any assessment amount that is due and payable to the
5 Illinois Department more frequently than once per calendar
6 quarter shall be remitted to the Illinois Department by the
7 hospital provider by means of electronic funds transfer. The
8 Illinois Department may provide for remittance by other means
9 if (i) the amount due is less than \$10,000 or (ii) electronic
10 funds transfer is unavailable for this purpose.

11 (Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08;
12 96-821, eff. 11-20-09.)

13 (305 ILCS 5/5A-5) (from Ch. 23, par. 5A-5)

14 Sec. 5A-5. Notice; penalty; maintenance of records.

15 (a) The Illinois Department ~~of Healthcare and Family~~
16 ~~Services~~ shall send a notice of assessment to every hospital
17 provider subject to assessment under this Article. The notice
18 of assessment shall notify the hospital of its assessment and
19 shall be sent after receipt by the Department of notification
20 from the Centers for Medicare and Medicaid Services of the U.S.
21 Department of Health and Human Services that the payment
22 methodologies required under this Article ~~Section 5A-12,~~
23 ~~Section 5A-12.1, or Section 5A-12.2, whichever is applicable~~
24 ~~for that fiscal year,~~ and, if necessary, the waiver granted
25 under 42 CFR 433.68 have been approved. The notice shall be on

1 a form prepared by the Illinois Department and shall state the
2 following:

3 (1) The name of the hospital provider.

4 (2) The address of the hospital provider's principal
5 place of business from which the provider engages in the
6 occupation of hospital provider in this State, and the name
7 and address of each hospital operated, conducted, or
8 maintained by the provider in this State.

9 (3) The occupied bed days, occupied bed days less
10 Medicare days, or adjusted gross hospital revenue of the
11 hospital provider (whichever is applicable), the amount of
12 assessment imposed under Section 5A-2 for the State fiscal
13 year for which the notice is sent, and the amount of each
14 installment to be paid during the State fiscal year.

15 (4) (Blank).

16 (5) Other reasonable information as determined by the
17 Illinois Department.

18 (b) If a hospital provider conducts, operates, or maintains
19 more than one hospital licensed by the Illinois Department of
20 Public Health, the provider shall pay the assessment for each
21 hospital separately.

22 (c) Notwithstanding any other provision in this Article, in
23 the case of a person who ceases to conduct, operate, or
24 maintain a hospital in respect of which the person is subject
25 to assessment under this Article as a hospital provider, the
26 assessment for the State fiscal year in which the cessation

1 occurs shall be adjusted by multiplying the assessment computed
2 under Section 5A-2 by a fraction, the numerator of which is the
3 number of days in the year during which the provider conducts,
4 operates, or maintains the hospital and the denominator of
5 which is 365. Immediately upon ceasing to conduct, operate, or
6 maintain a hospital, the person shall pay the assessment for
7 the year as so adjusted (to the extent not previously paid).

8 (d) Notwithstanding any other provision in this Article, a
9 provider who commences conducting, operating, or maintaining a
10 hospital, upon notice by the Illinois Department, shall pay the
11 assessment computed under Section 5A-2 and subsection (e) in
12 installments on the due dates stated in the notice and on the
13 regular installment due dates for the State fiscal year
14 occurring after the due dates of the initial notice.

15 ~~(e) Notwithstanding any other provision in this Article,~~
16 ~~for State fiscal years 2004 and 2005, in the case of a hospital~~
17 ~~provider that did not conduct, operate, or maintain a hospital~~
18 ~~throughout calendar year 2001, the assessment for that State~~
19 ~~fiscal year shall be computed on the basis of hypothetical~~
20 ~~occupied bed days for the full calendar year as determined by~~
21 ~~the Illinois Department. Notwithstanding any other provision~~
22 ~~in this Article, for State fiscal years 2006 through 2008, in~~
23 ~~the case of a hospital provider that did not conduct, operate,~~
24 ~~or maintain a hospital in 2003, the assessment for that State~~
25 ~~fiscal year shall be computed on the basis of hypothetical~~
26 ~~adjusted gross hospital revenue for the hospital's first full~~

1 ~~fiscal year as determined by the Illinois Department (which may~~
2 ~~be based on annualization of the provider's actual revenues for~~
3 ~~a portion of the year, or revenues of a comparable hospital for~~
4 ~~the year, including revenues realized by a prior provider of~~
5 ~~the same hospital during the year).~~ Notwithstanding any other
6 provision in this Article, for State fiscal years 2009 through
7 2012 2014, in the case of a hospital provider that did not
8 conduct, operate, or maintain a hospital in 2005, the
9 assessment for that State fiscal year shall be computed on the
10 basis of hypothetical occupied bed days for the full calendar
11 year as determined by the Illinois Department.

12 (e-5) Notwithstanding any other provision in this Article,
13 for State fiscal year 2013 and each subsequent State fiscal
14 year, in the case of a hospital provider that did not conduct,
15 operate, or maintain a hospital in 2005, the assessment for
16 that State fiscal year shall be computed on the basis of
17 hypothetical occupied bed days for the full calendar year as
18 determined by the Illinois Department.

19 (f) Every hospital provider subject to assessment under
20 this Article shall keep sufficient records to permit the
21 determination of adjusted gross hospital revenue for the
22 hospital's fiscal year. All such records shall be kept in the
23 English language and shall, at all times during regular
24 business hours of the day, be subject to inspection by the
25 Illinois Department or its duly authorized agents and
26 employees.

1 (g) The Illinois Department may, by rule, provide a
2 hospital provider a reasonable opportunity to request a
3 clarification or correction of any clerical or computational
4 errors contained in the calculation of its assessment, but such
5 corrections shall not extend to updating the cost report
6 information used to calculate the assessment.

7 (h) (Blank).

8 (Source: P.A. 95-331, eff. 8-21-07; 95-859, eff. 8-19-08;
9 96-1530, eff. 2-16-11.)

10 (305 ILCS 5/5A-6) (from Ch. 23, par. 5A-6)

11 Sec. 5A-6. Disposition of proceeds. The Illinois
12 Department shall deposit ~~pay~~ all moneys received from hospital
13 providers under this Article into the Hospital Provider Fund.
14 Upon certification by the Illinois Department to the State
15 Comptroller of its intent to withhold payments from a provider
16 pursuant to ~~under~~ Section 5A-7(b), the State Comptroller shall
17 draw a warrant on the treasury or other fund held by the State
18 Treasurer, as appropriate. The warrant shall state the amount
19 for which the provider is entitled to a warrant, the amount of
20 the deduction, and the reason therefor and shall direct the
21 State Treasurer to pay the balance to the provider, all in
22 accordance with Section 10.05 of the State Comptroller Act. The
23 warrant also shall direct the State Treasurer to transfer the
24 amount of the deduction so ordered from the treasury or other
25 fund into the Hospital Provider Fund.

1 (Source: P.A. 87-861.)

2 (305 ILCS 5/5A-8) (from Ch. 23, par. 5A-8)

3 Sec. 5A-8. Hospital Provider Fund.

4 (a) There is created in the State Treasury the Hospital
5 Provider Fund. Interest earned by the Fund shall be credited to
6 the Fund. The Fund shall not be used to replace any moneys
7 appropriated to the Medicaid program by the General Assembly.

8 (b) The Fund is created for the purpose of receiving moneys
9 in accordance with Section 5A-6 and disbursing moneys only for
10 the following purposes, notwithstanding any other provision of
11 law:

12 (1) For making payments to hospitals as required under
13 ~~Articles V, V A, VI, and XIV of this Code, under the~~
14 Children's Health Insurance Program Act, under the
15 Covering ALL KIDS Health Insurance Act, and under the Long
16 Term Acute Care Hospital Quality Improvement Transfer
17 Program Act. ~~Senior Citizens and Disabled Persons Property~~
18 ~~Tax Relief and Pharmaceutical Assistance Act.~~

19 (2) For the reimbursement of moneys collected by the
20 Illinois Department from hospitals or hospital providers
21 through error or mistake in performing the activities
22 authorized under ~~this Article and Article V of this Code.~~

23 (3) For payment of administrative expenses incurred by
24 the Illinois Department or its agent in performing ~~the~~
25 activities under authorized by this Code, the Children's

1 Health Insurance Program Act, the Covering ALL KIDS Health
2 Insurance Act, and the Long Term Acute Care Hospital
3 Quality Improvement Transfer Program Act. Article.

4 (4) For payments of any amounts which are reimbursable
5 to the federal government for payments from this Fund which
6 are required to be paid by State warrant.

7 (5) For making transfers, as those transfers are
8 authorized in the proceedings authorizing debt under the
9 Short Term Borrowing Act, but transfers made under this
10 paragraph (5) shall not exceed the principal amount of debt
11 issued in anticipation of the receipt by the State of
12 moneys to be deposited into the Fund.

13 (6) For making transfers to any other fund in the State
14 treasury, but transfers made under this paragraph (6) shall
15 not exceed the amount transferred previously from that
16 other fund into the Hospital Provider Fund plus any
17 interest that would have been earned by that fund on the
18 monies that had been transferred.

19 (6.5) For making transfers to the Healthcare Provider
20 Relief Fund, except that transfers made under this
21 paragraph (6.5) shall not exceed \$60,000,000 in the
22 aggregate.

23 (7) For making transfers not exceeding the following
24 amounts, in each State fiscal year during which an
25 assessment is imposed pursuant to Section 5A-2, to the
26 following designated funds:

Health and Human Services Medicaid Trust

Fund \$20,000,000

Long-Term Care Provider Fund \$30,000,000

General Revenue Fund \$80,000,000.

Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4. For State fiscal years 2004 and 2005 for making transfers to the Health and Human Services Medicaid Trust Fund, including 20% of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6. For State fiscal year 2006 for making transfers to the Health and Human Services Medicaid Trust Fund of up to \$130,000,000 per year of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6. Transfers under this paragraph shall be made within 7 days after the payments have been received pursuant to the schedule of payments provided in subsection (a) of Section 5A-4.

(7.5) (Blank). ~~For State fiscal year 2007 for making transfers of the moneys received from hospital providers under Section 5A-4 and transferred into the Hospital Provider Fund under Section 5A-6 to the designated funds not exceeding the following amounts in that State fiscal year:~~

~~Health and Human Services~~

| | | |
|---|---|---------------------------|
| 1 | Medicaid Trust Fund | \$20,000,000 |
| 2 | Long Term Care Provider Fund | -\$30,000,000 |
| 3 | General Revenue Fund | -\$80,000,000. |

4 ~~Transfers under this paragraph shall be made within 7~~
5 ~~days after the payments have been received pursuant to the~~
6 ~~schedule of payments provided in subsection (a) of Section~~
7 ~~5A-4.~~

8 (7.8) (Blank). ~~For State fiscal year 2008, for making~~
9 ~~transfers of the moneys received from hospital providers~~
10 ~~under Section 5A-4 and transferred into the Hospital~~
11 ~~Provider Fund under Section 5A-6 to the designated funds~~
12 ~~not exceeding the following amounts in that State fiscal~~
13 ~~year:~~

14 ~~Health and Human Services~~

| | | |
|----|---|---------------------------|
| 15 | Medicaid Trust Fund | \$40,000,000 |
| 16 | Long Term Care Provider Fund | \$60,000,000 |
| 17 | General Revenue Fund | \$160,000,000. |

18 ~~Transfers under this paragraph shall be made within 7~~
19 ~~days after the payments have been received pursuant to the~~
20 ~~schedule of payments provided in subsection (a) of Section~~
21 ~~5A-4.~~

22 (7.9) (Blank). ~~For State fiscal years 2009 through~~
23 ~~2014, for making transfers of the moneys received from~~
24 ~~hospital providers under Section 5A-4 and transferred into~~
25 ~~the Hospital Provider Fund under Section 5A-6 to the~~
26 ~~designated funds not exceeding the following amounts in~~

1 ~~that State fiscal year:~~

2 ~~Health and Human Services~~

3 ~~Medicaid Trust Fund \$20,000,000~~

4 ~~Long Term Care Provider Fund \$30,000,000~~

5 ~~General Revenue Fund \$80,000,000.~~

6 ~~Except as provided under this paragraph, transfers~~
7 ~~under this paragraph shall be made within 7 business days~~
8 ~~after the payments have been received pursuant to the~~
9 ~~schedule of payments provided in subsection (a) of Section~~
10 ~~5A-4. For State fiscal year 2009, transfers to the General~~
11 ~~Revenue Fund under this paragraph shall be made on or~~
12 ~~before June 30, 2009, as sufficient funds become available~~
13 ~~in the Hospital Provider Fund to both make the transfers~~
14 ~~and continue hospital payments.~~

15 (8) For making refunds to hospital providers pursuant
16 to Section 5A-10.

17 Disbursements from the Fund, other than transfers
18 authorized under paragraphs (5) and (6) of this subsection,
19 shall be by warrants drawn by the State Comptroller upon
20 receipt of vouchers duly executed and certified by the Illinois
21 Department.

22 (c) The Fund shall consist of the following:

23 (1) All moneys collected or received by the Illinois
24 Department from the hospital provider assessment imposed
25 by this Article.

26 (2) All federal matching funds received by the Illinois

1 Department as a result of expenditures made by the Illinois
2 Department that are attributable to moneys deposited in the
3 Fund.

4 (3) Any interest or penalty levied in conjunction with
5 the administration of this Article.

6 (4) Moneys transferred from another fund in the State
7 treasury.

8 (5) All other moneys received for the Fund from any
9 other source, including interest earned thereon.

10 (d) (Blank).

11 (Source: P.A. 95-707, eff. 1-11-08; 95-859, eff. 8-19-08; 96-3,
12 eff. 2-27-09; 96-45, eff. 7-15-09; 96-821, eff. 11-20-09;
13 96-1530, eff. 2-16-11.)

14 (305 ILCS 5/5A-10) (from Ch. 23, par. 5A-10)

15 Sec. 5A-10. Applicability.

16 (a) The assessment imposed by Section 5A-2 shall ~~not take~~
17 ~~effect or shall~~ cease to be imposed and the Department's
18 obligation to make payments shall immediately cease, and any
19 moneys remaining in the Fund shall be refunded to hospital
20 providers in proportion to the amounts paid by them, if:

21 (1) The payments to hospitals required under this
22 Article are not eligible for federal matching funds under
23 Title XIX or XXI of the Social Security Act ~~The sum of the~~
24 ~~appropriations for State fiscal years 2004 and 2005 from~~
25 ~~the General Revenue Fund for hospital payments under the~~

1 ~~medical assistance program is less than \$4,500,000,000 or~~
2 ~~the appropriation for each of State fiscal years 2006, 2007~~
3 ~~and 2008 from the General Revenue Fund for hospital~~
4 ~~payments under the medical assistance program is less than~~
5 ~~\$2,500,000,000 increased annually to reflect any increase~~
6 ~~in the number of recipients, or the annual appropriation~~
7 ~~for State fiscal years 2009, 2010, 2011, 2013, and 2014,~~
8 ~~from the General Revenue Fund combined with the Hospital~~
9 ~~Provider Fund as authorized in Section 5A-8 for hospital~~
10 ~~payments under the medical assistance program, is less than~~
11 ~~the amount appropriated for State fiscal year 2009,~~
12 ~~adjusted annually to reflect any change in the number of~~
13 ~~recipients, excluding State fiscal year 2009 supplemental~~
14 ~~appropriations made necessary by the enactment of the~~
15 ~~American Recovery and Reinvestment Act of 2009; or~~

16 ~~(2) For State fiscal years prior to State fiscal year~~
17 ~~2009, the Department of Healthcare and Family Services~~
18 ~~(formerly Department of Public Aid) makes changes in its~~
19 ~~rules that reduce the hospital inpatient or outpatient~~
20 ~~payment rates, including adjustment payment rates, in~~
21 ~~effect on October 1, 2004, except for hospitals described~~
22 ~~in subsection (b) of Section 5A-3 and except for changes in~~
23 ~~the methodology for calculating outlier payments to~~
24 ~~hospitals for exceptionally costly stays, so long as those~~
25 ~~changes do not reduce aggregate expenditures below the~~
26 ~~amount expended in State fiscal year 2005 for such~~

1 ~~services; or~~

2 (2) ~~(2.1)~~ For State fiscal years 2009 through 2014 and
3 July 1, 2014 through December 31, 2014, the Department of
4 Healthcare and Family Services adopts any administrative
5 rule change to reduce payment rates or alters any payment
6 methodology that reduces any payment rates made to
7 operating hospitals under the approved Title XIX or Title
8 XXI State plan in effect January 1, 2008 except for:

9 (A) any changes for hospitals described in
10 subsection (b) of Section 5A-3; or

11 (B) any rates for payments made under this Article
12 V-A; or

13 (C) any changes proposed in State plan amendment
14 transmittal numbers 08-01, 08-02, 08-04, 08-06, and
15 08-07; ~~or~~

16 (D) in relation to any admissions on or after
17 January 1, 2011, a modification in the methodology for
18 calculating outlier payments to hospitals for
19 exceptionally costly stays, for hospitals reimbursed
20 under the diagnosis-related grouping methodology in
21 effect on January 1, 2011; provided that the Department
22 shall be limited to one such modification during the
23 36-month period after the effective date of this
24 amendatory Act of the 96th General Assembly; or

25 (E) any changes affecting hospitals authorized by
26 this amendatory Act of the 97th General Assembly.

1 ~~(3) The payments to hospitals required under Section~~
2 ~~5A-12 or Section 5A-12.2 are changed or are not eligible~~
3 ~~for federal matching funds under Title XIX or XXI of the~~
4 ~~Social Security Act.~~

5 (b) The assessment imposed by Section 5A-2 shall not take
6 effect or shall cease to be imposed and the Department's
7 obligation to make payments shall immediately cease if the
8 assessment is determined to be an impermissible tax under Title
9 XIX of the Social Security Act. Moneys in the Hospital Provider
10 Fund derived from assessments imposed prior thereto shall be
11 disbursed in accordance with Section 5A-8 to the extent federal
12 financial participation is not reduced due to the
13 impermissibility of the assessments, and any remaining moneys
14 shall be refunded to hospital providers in proportion to the
15 amounts paid by them.

16 (Source: P.A. 96-8, eff. 4-28-09; 96-1530, eff. 2-16-11; 97-72,
17 eff. 7-1-11; 97-74, eff. 6-30-11.)

18 (305 ILCS 5/5A-12.2)

19 (Section scheduled to be repealed on July 1, 2014)

20 Sec. 5A-12.2. Hospital access payments on or after July 1,
21 2008.

22 (a) To preserve and improve access to hospital services,
23 for hospital services rendered on or after July 1, 2008, the
24 Illinois Department shall, except for hospitals described in
25 subsection (b) of Section 5A-3, make payments to hospitals as

1 set forth in this Section. These payments shall be paid in 12
2 equal installments on or before the seventh State business day
3 of each month, except that no payment shall be due within 100
4 days after the later of the date of notification of federal
5 approval of the payment methodologies required under this
6 Section or any waiver required under 42 CFR 433.68, at which
7 time the sum of amounts required under this Section prior to
8 the date of notification is due and payable. Payments under
9 this Section are not due and payable, however, until (i) the
10 methodologies described in this Section are approved by the
11 federal government in an appropriate State Plan amendment and
12 (ii) the assessment imposed under this Article is determined to
13 be a permissible tax under Title XIX of the Social Security
14 Act.

15 (a-5) The Illinois Department may, when practicable,
16 accelerate the schedule upon which payments authorized under
17 this Section are made.

18 (b) Across-the-board inpatient adjustment.

19 (1) In addition to rates paid for inpatient hospital
20 services, the Department shall pay to each Illinois general
21 acute care hospital an amount equal to 40% of the total
22 base inpatient payments paid to the hospital for services
23 provided in State fiscal year 2005.

24 (2) In addition to rates paid for inpatient hospital
25 services, the Department shall pay to each freestanding
26 Illinois specialty care hospital as defined in 89 Ill. Adm.

1 Code 149.50(c)(1), (2), or (4) an amount equal to 60% of
2 the total base inpatient payments paid to the hospital for
3 services provided in State fiscal year 2005.

4 (3) In addition to rates paid for inpatient hospital
5 services, the Department shall pay to each freestanding
6 Illinois rehabilitation or psychiatric hospital an amount
7 equal to \$1,000 per Medicaid inpatient day multiplied by
8 the increase in the hospital's Medicaid inpatient
9 utilization ratio (determined using the positive
10 percentage change from the rate year 2005 Medicaid
11 inpatient utilization ratio to the rate year 2007 Medicaid
12 inpatient utilization ratio, as calculated by the
13 Department for the disproportionate share determination).

14 (4) In addition to rates paid for inpatient hospital
15 services, the Department shall pay to each Illinois
16 children's hospital an amount equal to 20% of the total
17 base inpatient payments paid to the hospital for services
18 provided in State fiscal year 2005 and an additional amount
19 equal to 20% of the base inpatient payments paid to the
20 hospital for psychiatric services provided in State fiscal
21 year 2005.

22 (5) In addition to rates paid for inpatient hospital
23 services, the Department shall pay to each Illinois
24 hospital eligible for a pediatric inpatient adjustment
25 payment under 89 Ill. Adm. Code 148.298, as in effect for
26 State fiscal year 2007, a supplemental pediatric inpatient

1 adjustment payment equal to:

2 (i) For freestanding children's hospitals as
3 defined in 89 Ill. Adm. Code 149.50(c)(3)(A), 2.5
4 multiplied by the hospital's pediatric inpatient
5 adjustment payment required under 89 Ill. Adm. Code
6 148.298, as in effect for State fiscal year 2008.

7 (ii) For hospitals other than freestanding
8 children's hospitals as defined in 89 Ill. Adm. Code
9 149.50(c)(3)(B), 1.0 multiplied by the hospital's
10 pediatric inpatient adjustment payment required under
11 89 Ill. Adm. Code 148.298, as in effect for State
12 fiscal year 2008.

13 (c) Outpatient adjustment.

14 (1) In addition to the rates paid for outpatient
15 hospital services, the Department shall pay each Illinois
16 hospital an amount equal to 2.2 multiplied by the
17 hospital's ambulatory procedure listing payments for
18 categories 1, 2, 3, and 4, as defined in 89 Ill. Adm. Code
19 148.140(b), for State fiscal year 2005.

20 (2) In addition to the rates paid for outpatient
21 hospital services, the Department shall pay each Illinois
22 freestanding psychiatric hospital an amount equal to 3.25
23 multiplied by the hospital's ambulatory procedure listing
24 payments for category 5b, as defined in 89 Ill. Adm. Code
25 148.140(b)(1)(E), for State fiscal year 2005.

26 (d) Medicaid high volume adjustment. In addition to rates

1 paid for inpatient hospital services, the Department shall pay
2 to each Illinois general acute care hospital that provided more
3 than 20,500 Medicaid inpatient days of care in State fiscal
4 year 2005 amounts as follows:

5 (1) For hospitals with a case mix index equal to or
6 greater than the 85th percentile of hospital case mix
7 indices, \$350 for each Medicaid inpatient day of care
8 provided during that period; and

9 (2) For hospitals with a case mix index less than the
10 85th percentile of hospital case mix indices, \$100 for each
11 Medicaid inpatient day of care provided during that period.

12 (e) Capital adjustment. In addition to rates paid for
13 inpatient hospital services, the Department shall pay an
14 additional payment to each Illinois general acute care hospital
15 that has a Medicaid inpatient utilization rate of at least 10%
16 (as calculated by the Department for the rate year 2007
17 disproportionate share determination) amounts as follows:

18 (1) For each Illinois general acute care hospital that
19 has a Medicaid inpatient utilization rate of at least 10%
20 and less than 36.94% and whose capital cost is less than
21 the 60th percentile of the capital costs of all Illinois
22 hospitals, the amount of such payment shall equal the
23 hospital's Medicaid inpatient days multiplied by the
24 difference between the capital costs at the 60th percentile
25 of the capital costs of all Illinois hospitals and the
26 hospital's capital costs.

1 (2) For each Illinois general acute care hospital that
2 has a Medicaid inpatient utilization rate of at least
3 36.94% and whose capital cost is less than the 75th
4 percentile of the capital costs of all Illinois hospitals,
5 the amount of such payment shall equal the hospital's
6 Medicaid inpatient days multiplied by the difference
7 between the capital costs at the 75th percentile of the
8 capital costs of all Illinois hospitals and the hospital's
9 capital costs.

10 (f) Obstetrical care adjustment.

11 (1) In addition to rates paid for inpatient hospital
12 services, the Department shall pay \$1,500 for each Medicaid
13 obstetrical day of care provided in State fiscal year 2005
14 by each Illinois rural hospital that had a Medicaid
15 obstetrical percentage (Medicaid obstetrical days divided
16 by Medicaid inpatient days) greater than 15% for State
17 fiscal year 2005.

18 (2) In addition to rates paid for inpatient hospital
19 services, the Department shall pay \$1,350 for each Medicaid
20 obstetrical day of care provided in State fiscal year 2005
21 by each Illinois general acute care hospital that was
22 designated a level III perinatal center as of December 31,
23 2006, and that had a case mix index equal to or greater
24 than the 45th percentile of the case mix indices for all
25 level III perinatal centers.

26 (3) In addition to rates paid for inpatient hospital

1 services, the Department shall pay \$900 for each Medicaid
2 obstetrical day of care provided in State fiscal year 2005
3 by each Illinois general acute care hospital that was
4 designated a level II or II+ perinatal center as of
5 December 31, 2006, and that had a case mix index equal to
6 or greater than the 35th percentile of the case mix indices
7 for all level II and II+ perinatal centers.

8 (g) Trauma adjustment.

9 (1) In addition to rates paid for inpatient hospital
10 services, the Department shall pay each Illinois general
11 acute care hospital designated as a trauma center as of
12 July 1, 2007, a payment equal to 3.75 multiplied by the
13 hospital's State fiscal year 2005 Medicaid capital
14 payments.

15 (2) In addition to rates paid for inpatient hospital
16 services, the Department shall pay \$400 for each Medicaid
17 acute inpatient day of care provided in State fiscal year
18 2005 by each Illinois general acute care hospital that was
19 designated a level II trauma center, as defined in 89 Ill.
20 Adm. Code 148.295(a)(3) and 148.295(a)(4), as of July 1,
21 2007.

22 (3) In addition to rates paid for inpatient hospital
23 services, the Department shall pay \$235 for each Illinois
24 Medicaid acute inpatient day of care provided in State
25 fiscal year 2005 by each level I pediatric trauma center
26 located outside of Illinois that had more than 8,000

1 Illinois Medicaid inpatient days in State fiscal year 2005.

2 (h) Supplemental tertiary care adjustment. In addition to
3 rates paid for inpatient services, the Department shall pay to
4 each Illinois hospital eligible for tertiary care adjustment
5 payments under 89 Ill. Adm. Code 148.296, as in effect for
6 State fiscal year 2007, a supplemental tertiary care adjustment
7 payment equal to the tertiary care adjustment payment required
8 under 89 Ill. Adm. Code 148.296, as in effect for State fiscal
9 year 2007.

10 (i) Crossover adjustment. In addition to rates paid for
11 inpatient services, the Department shall pay each Illinois
12 general acute care hospital that had a ratio of crossover days
13 to total inpatient days for medical assistance programs
14 administered by the Department (utilizing information from
15 2005 paid claims) greater than 50%, and a case mix index
16 greater than the 65th percentile of case mix indices for all
17 Illinois hospitals, a rate of \$1,125 for each Medicaid
18 inpatient day including crossover days.

19 (j) Magnet hospital adjustment. In addition to rates paid
20 for inpatient hospital services, the Department shall pay to
21 each Illinois general acute care hospital and each Illinois
22 freestanding children's hospital that, as of February 1, 2008,
23 was recognized as a Magnet hospital by the American Nurses
24 Credentialing Center and that had a case mix index greater than
25 the 75th percentile of case mix indices for all Illinois
26 hospitals amounts as follows:

1 (1) For hospitals located in a county whose eligibility
2 growth factor is greater than the mean, \$450 multiplied by
3 the eligibility growth factor for the county in which the
4 hospital is located for each Medicaid inpatient day of care
5 provided by the hospital during State fiscal year 2005.

6 (2) For hospitals located in a county whose eligibility
7 growth factor is less than or equal to the mean, \$225
8 multiplied by the eligibility growth factor for the county
9 in which the hospital is located for each Medicaid
10 inpatient day of care provided by the hospital during State
11 fiscal year 2005.

12 For purposes of this subsection, "eligibility growth
13 factor" means the percentage by which the number of Medicaid
14 recipients in the county increased from State fiscal year 1998
15 to State fiscal year 2005.

16 (k) For purposes of this Section, a hospital that is
17 enrolled to provide Medicaid services during State fiscal year
18 2005 shall have its utilization and associated reimbursements
19 annualized prior to the payment calculations being performed
20 under this Section.

21 (1) For purposes of this Section, the terms "Medicaid
22 days", "ambulatory procedure listing services", and
23 "ambulatory procedure listing payments" do not include any
24 days, charges, or services for which Medicare or a managed care
25 organization reimbursed on a capitated basis was liable for
26 payment, except where explicitly stated otherwise in this

1 Section.

2 (m) For purposes of this Section, in determining the
3 percentile ranking of an Illinois hospital's case mix index or
4 capital costs, hospitals described in subsection (b) of Section
5 5A-3 shall be excluded from the ranking.

6 (n) Definitions. Unless the context requires otherwise or
7 unless provided otherwise in this Section, the terms used in
8 this Section for qualifying criteria and payment calculations
9 shall have the same meanings as those terms have been given in
10 the Illinois Department's administrative rules as in effect on
11 March 1, 2008. Other terms shall be defined by the Illinois
12 Department by rule.

13 As used in this Section, unless the context requires
14 otherwise:

15 "Base inpatient payments" means, for a given hospital, the
16 sum of base payments for inpatient services made on a per diem
17 or per admission (DRG) basis, excluding those portions of per
18 admission payments that are classified as capital payments.
19 Disproportionate share hospital adjustment payments, Medicaid
20 Percentage Adjustments, Medicaid High Volume Adjustments, and
21 outlier payments, as defined by rule by the Department as of
22 January 1, 2008, are not base payments.

23 "Capital costs" means, for a given hospital, the total
24 capital costs determined using the most recent 2005 Medicare
25 cost report as contained in the Healthcare Cost Report
26 Information System file, for the quarter ending on December 31,

1 2006, divided by the total inpatient days from the same cost
2 report to calculate a capital cost per day. The resulting
3 capital cost per day is inflated to the midpoint of State
4 fiscal year 2009 utilizing the national hospital market price
5 proxies (DRI) hospital cost index. If a hospital's 2005
6 Medicare cost report is not contained in the Healthcare Cost
7 Report Information System, the Department may obtain the data
8 necessary to compute the hospital's capital costs from any
9 source available, including, but not limited to, records
10 maintained by the hospital provider, which may be inspected at
11 all times during business hours of the day by the Illinois
12 Department or its duly authorized agents and employees.

13 "Case mix index" means, for a given hospital, the sum of
14 the DRG relative weighting factors in effect on January 1,
15 2005, for all general acute care admissions for State fiscal
16 year 2005, excluding Medicare crossover admissions and
17 transplant admissions reimbursed under 89 Ill. Adm. Code
18 148.82, divided by the total number of general acute care
19 admissions for State fiscal year 2005, excluding Medicare
20 crossover admissions and transplant admissions reimbursed
21 under 89 Ill. Adm. Code 148.82.

22 "Medicaid inpatient day" means, for a given hospital, the
23 sum of days of inpatient hospital days provided to recipients
24 of medical assistance under Title XIX of the federal Social
25 Security Act, excluding days for individuals eligible for
26 Medicare under Title XVIII of that Act (Medicaid/Medicare

1 crossover days), as tabulated from the Department's paid claims
2 data for admissions occurring during State fiscal year 2005
3 that was adjudicated by the Department through March 23, 2007.

4 "Medicaid obstetrical day" means, for a given hospital, the
5 sum of days of inpatient hospital days grouped by the
6 Department to DRGs of 370 through 375 provided to recipients of
7 medical assistance under Title XIX of the federal Social
8 Security Act, excluding days for individuals eligible for
9 Medicare under Title XVIII of that Act (Medicaid/Medicare
10 crossover days), as tabulated from the Department's paid claims
11 data for admissions occurring during State fiscal year 2005
12 that was adjudicated by the Department through March 23, 2007.

13 "Outpatient ambulatory procedure listing payments" means,
14 for a given hospital, the sum of payments for ambulatory
15 procedure listing services, as described in 89 Ill. Adm. Code
16 148.140(b), provided to recipients of medical assistance under
17 Title XIX of the federal Social Security Act, excluding
18 payments for individuals eligible for Medicare under Title
19 XVIII of the Act (Medicaid/Medicare crossover days), as
20 tabulated from the Department's paid claims data for services
21 occurring in State fiscal year 2005 that were adjudicated by
22 the Department through March 23, 2007.

23 (o) The Department may adjust payments made under this
24 Section 5A-12.2 ~~12.2~~ to comply with federal law or regulations
25 regarding hospital-specific payment limitations on
26 government-owned or government-operated hospitals.

1 (p) Notwithstanding any of the other provisions of this
2 Section, the Department is authorized to adopt rules that
3 change the hospital access improvement payments specified in
4 this Section, but only to the extent necessary to conform to
5 any federally approved amendment to the Title XIX State plan.
6 Any such rules shall be adopted by the Department as authorized
7 by Section 5-50 of the Illinois Administrative Procedure Act.
8 Notwithstanding any other provision of law, any changes
9 implemented as a result of this subsection (p) shall be given
10 retroactive effect so that they shall be deemed to have taken
11 effect as of the effective date of this Section.

12 (q) (Blank). ~~For State fiscal years 2012 and 2013, the~~
13 ~~Department may make recommendations to the General Assembly~~
14 ~~regarding the use of more recent data for purposes of~~
15 ~~calculating the assessment authorized under Section 5A-2 and~~
16 ~~the payments authorized under this Section 5A-12.2.~~

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

22 (Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09.)

23 (305 ILCS 5/5A-14)

24 Sec. 5A-14. Repeal of assessments and disbursements.

25 (a) Section 5A-2 is repealed on January 1, 2015 ~~July 1,~~

1 ~~2014.~~

2 (b) Section 5A-12 is repealed on July 1, 2005.

3 (c) Section 5A-12.1 is repealed on July 1, 2008.

4 (d) Section 5A-12.2 is repealed on January 1, 2015 ~~July 1,~~
5 ~~2014.~~

6 (e) Section 5A-12.3 is repealed on July 1, 2011.

7 (Source: P.A. 95-859, eff. 8-19-08; 96-821, eff. 11-20-09;
8 96-1530, eff. 2-16-11.)

9 (305 ILCS 5/5A-15 new)

10 Sec. 5A-15. Protection of federal revenue.

11 (a) If the federal Centers for Medicare and Medicaid
12 Services finds that any federal upper payment limit applicable
13 to the payments under this Article is exceeded then:

14 (1) the payments under this Article that exceed the
15 applicable federal upper payment limit shall be reduced
16 uniformly to the extent necessary to comply with the
17 applicable federal upper payment limit; and

18 (2) any assessment rate imposed under this Article
19 shall be reduced such that the aggregate assessment is
20 reduced by the same percentage reduction applied in
21 paragraph (1); and

22 (3) any transfers from the Hospital Provider Fund under
23 Section 5A-8 shall be reduced by the same percentage
24 reduction applied in paragraph (1).

25 (b) Any payment reductions made under the authority granted

1 in this Section are exempt from the requirements and actions
2 under Section 5A-10.

3 (305 ILCS 5/6-11) (from Ch. 23, par. 6-11)

4 Sec. 6-11. ~~State funded~~ General Assistance.

5 (a) Effective July 1, 1992, all State funded General
6 Assistance and related medical benefits shall be governed by
7 this Section, provided that, notwithstanding any other
8 provisions of this Code to the contrary, on and after July 1,
9 2012, the State shall not fund the programs outlined in this
10 Section. Other parts of this Code or other laws related to
11 General Assistance shall remain in effect to the extent they do
12 not conflict with the provisions of this Section. If any other
13 part of this Code or other laws of this State conflict with the
14 provisions of this Section, the provisions of this Section
15 shall control.

16 (b) ~~State funded~~ General Assistance may shall consist of 2
17 separate programs. One program shall be for adults with no
18 children and shall be known as ~~State~~ Transitional Assistance.
19 The other program may shall be for families with children and
20 for pregnant women and shall be known as ~~State~~ Family and
21 Children Assistance.

22 (c) (1) To be eligible for ~~State~~ Transitional Assistance on
23 or after July 1, 1992, an individual must be ineligible for
24 assistance under any other Article of this Code, must be
25 determined chronically needy, and must be one of the following:

1 (A) age 18 or over or

2 (B) married and living with a spouse, regardless of
3 age.

4 (2) The ~~Illinois Department or the~~ local governmental unit
5 shall determine whether individuals are chronically needy as
6 follows:

7 (A) Individuals who have applied for Supplemental
8 Security Income (SSI) and are awaiting a decision on
9 eligibility for SSI who are determined disabled by the
10 Illinois Department using the SSI standard shall be
11 considered chronically needy, except that individuals
12 whose disability is based solely on substance addictions
13 (drug abuse and alcoholism) and whose disability would
14 cease were their addictions to end shall be eligible only
15 for medical assistance and shall not be eligible for cash
16 assistance under the ~~State~~ Transitional Assistance
17 program.

18 (B) (Blank). ~~If an individual has been denied SSI due~~
19 ~~to a finding of "not disabled" (either at the~~
20 ~~Administrative Law Judge level or above, or at a lower~~
21 ~~level if that determination was not appealed), the Illinois~~
22 ~~Department shall adopt that finding and the individual~~
23 ~~shall not be eligible for State Transitional Assistance or~~
24 ~~any related medical benefits. Such an individual may not be~~
25 ~~determined disabled by the Illinois Department for a period~~
26 ~~of 12 months, unless the individual shows that there has~~

1 ~~been a substantial change in his or her medical condition~~
2 ~~or that there has been a substantial change in other~~
3 ~~factors, such as age or work experience, that might change~~
4 ~~the determination of disability.~~

5 (C) The unit of local government ~~Illinois Department,~~
6 ~~by rule,~~ may specify other categories of individuals as
7 chronically needy; nothing in this Section, however, shall
8 be deemed to require the inclusion of any specific category
9 other than as specified in paragraph ~~paragraphs~~ (A) ~~and~~
10 ~~(B).~~

11 (3) For individuals in ~~State~~ Transitional Assistance,
12 medical assistance ~~may shall~~ be provided by the unit of local
13 government in an amount and nature determined by the unit of
14 local government. ~~Nothing Department of Healthcare and Family~~
15 ~~Services by rule. The amount and nature of medical assistance~~
16 ~~provided need not be the same as that provided under paragraph~~
17 ~~(4) of subsection (d) of this Section, and nothing in this~~
18 paragraph (3) shall be construed to require the coverage of any
19 particular medical service. In addition, the amount and nature
20 of medical assistance provided may be different for different
21 categories of individuals determined chronically needy.

22 (4) (Blank). ~~The Illinois Department shall determine, by~~
23 ~~rule, those assistance recipients under Article VI who shall be~~
24 ~~subject to employment, training, or education programs~~
25 ~~including Earnfare, the content of those programs, and the~~
26 ~~penalties for failure to cooperate in those programs.~~

1 (5) (Blank). ~~The Illinois Department shall, by rule,~~
2 ~~establish further eligibility requirements, including but not~~
3 ~~limited to residence, need, and the level of payments.~~

4 (d) (1) To be eligible for ~~State~~ Family and Children
5 Assistance, a family unit must be ineligible for assistance
6 under any other Article of this Code and must contain a child
7 who is:

8 (A) under age 18 or

9 (B) age 18 and a full-time student in a secondary
10 school or the equivalent level of vocational or technical
11 training, and who may reasonably be expected to complete
12 the program before reaching age 19.

13 Those children shall be eligible for ~~State~~ Family and
14 Children Assistance.

15 (2) The natural or adoptive parents of the child living in
16 the same household may be eligible for ~~State~~ Family and
17 Children Assistance.

18 (3) A pregnant woman whose pregnancy has been verified
19 shall be eligible for income maintenance assistance under the
20 ~~State~~ Family and Children Assistance program.

21 (4) The amount and nature of medical assistance provided
22 under the ~~State~~ Family and Children Assistance program shall be
23 determined by the unit of local government ~~Department of~~
24 ~~Healthcare and Family Services by rule~~. The amount and nature
25 of medical assistance provided need not be the same as that
26 provided under paragraph (3) of subsection (c) of this Section,

1 and nothing in this paragraph (4) shall be construed to require
2 the coverage of any particular medical service.

3 (5) (Blank). ~~The Illinois Department shall, by rule,~~
4 ~~establish further eligibility requirements, including but not~~
5 ~~limited to residence, need, and the level of payments.~~

6 (e) A local governmental unit that chooses to participate
7 in a General Assistance program under this Section shall
8 provide funding in accordance with Section 12-21.13 of this
9 Act. Local governmental funds used to qualify for State funding
10 may only be expended for clients eligible for assistance under
11 this Section 6-11 and related administrative expenses.

12 (f) (Blank). ~~In order to qualify for State funding under~~
13 ~~this Section, a local governmental unit shall be subject to the~~
14 ~~supervision and the rules and regulations of the Illinois~~
15 ~~Department.~~

16 (g) (Blank). ~~Notwithstanding any other provision in this~~
17 ~~Code, the Illinois Department is authorized to reduce payment~~
18 ~~levels used to determine cash grants provided to recipients of~~
19 ~~State Transitional Assistance at any time within a Fiscal Year~~
20 ~~in order to ensure that cash benefits for State Transitional~~
21 ~~Assistance do not exceed the amounts appropriated for those~~
22 ~~cash benefits. Changes in payment levels may be accomplished by~~
23 ~~emergency rule under Section 5-45 of the Illinois~~
24 ~~Administrative Procedure Act, except that the limitation on the~~
25 ~~number of emergency rules that may be adopted in a 24 month~~
26 ~~period shall not apply and the provisions of Sections 5-115 and~~

1 ~~5-125 of the Illinois Administrative Procedure Act shall not~~
2 ~~apply. This provision shall also be applicable to any reduction~~
3 ~~in payment levels made upon implementation of this amendatory~~
4 ~~Act of 1995.~~

5 (Source: P.A. 95-331, eff. 8-21-07.)

6 (305 ILCS 5/11-5.2 new)

7 Sec. 11-5.2. Income, Residency, and Identity Verification
8 System.

9 (a) The Department shall ensure that its proposed
10 integrated eligibility system shall include the computerized
11 functions of income, residency, and identity eligibility
12 verification to verify eligibility, eliminate duplication of
13 medical assistance, and deter fraud. Until the integrated
14 eligibility system is operational, the Department may enter
15 into a contract with the vendor selected pursuant to Section
16 11-5.3 as necessary to obtain the electronic data matching
17 described in this Section. This contract shall be exempt from
18 the Illinois Procurement Code pursuant to subsection (h) of
19 Section 1-10 of that Code.

20 (b) Prior to awarding medical assistance at application
21 under Article V of this Code, the Department shall, to the
22 extent such databases are available to the Department, conduct
23 data matches using the name, date of birth, address, and Social
24 Security Number of each applicant or recipient or responsible
25 relative of an applicant or recipient against the following:

1 (1) Income tax information.

2 (2) Employer reports of income and unemployment
3 insurance payment information maintained by the Department
4 of Employment Security.

5 (3) Earned and unearned income, citizenship and death,
6 and other relevant information maintained by the Social
7 Security Administration.

8 (4) Immigration status information maintained by the
9 United States Citizenship and Immigration Services.

10 (5) Wage reporting and similar information maintained
11 by states contiguous to this State.

12 (6) Employment information maintained by the
13 Department of Employment Security in its New Hire Directory
14 database.

15 (7) Employment information maintained by the United
16 States Department of Health and Human Services in its
17 National Directory of New Hires database.

18 (8) Veterans' benefits information maintained by the
19 United States Department of Health and Human Services, in
20 coordination with the Department of Health and Human
21 Services and the Department of Veterans' Affairs, in the
22 federal Public Assistance Reporting Information System
23 (PARIS) database.

24 (9) Residency information maintained by the Illinois
25 Secretary of State.

26 (10) A database which is substantially similar to or a

1 successor of a database described in this Section that
2 contains information relevant for verifying eligibility
3 for medical assistance.

4 (d) If a discrepancy results between information provided
5 by an applicant, recipient, or responsible relative and
6 information contained in one or more of the databases or
7 information tools listed under subsection (b) or (c) of this
8 Section or subsection (c) of Section 11-5.3 and that
9 discrepancy calls into question the accuracy of information
10 relevant to a condition of eligibility provided by the
11 applicant, recipient, or responsible relative, the Department
12 or its contractor shall review the applicant's or recipient's
13 case using the following procedures:

14 (1) If the information discovered under subsection (c)
15 of this Section or subsection (c) of Section 11-5.3 does
16 not result in the Department finding the applicant or
17 recipient ineligible for assistance under Article V of this
18 Code, the Department shall finalize the determination or
19 redetermination of eligibility.

20 (2) If the information discovered results in the
21 Department finding the applicant or recipient ineligible
22 for assistance, the Department shall provide notice as set
23 forth in Section 11-7 of this Article.

24 (3) If the information discovered is insufficient to
25 determine that the applicant or recipient is eligible or
26 ineligible, the Department shall provide written notice to

1 the applicant or recipient which shall describe in
2 sufficient detail the circumstances of the discrepancy,
3 the information or documentation required, the manner in
4 which the applicant or recipient may respond, and the
5 consequences of failing to take action. The applicant or
6 recipient shall have 10 business days to respond.

7 (4) If the applicant or recipient does not respond to
8 the notice, the Department shall deny assistance for
9 failure to cooperate, in which case the Department shall
10 provide notice as set forth in Section 11-7. Eligibility
11 for assistance shall not be established until the
12 discrepancy has been resolved.

13 (5) If an applicant or recipient responds to the
14 notice, the Department shall determine the effect of the
15 information or documentation provided on the applicant's
16 or recipient's case and shall take appropriate action.
17 Written notice of the Department's action shall be provided
18 as set forth in Section 11-7 of this Article.

19 (6) Suspected cases of fraud shall be referred to the
20 Department's Inspector General.

21 (e) The Department shall adopt any rules necessary to
22 implement this Section.

23 (305 ILCS 5/11-5.3 new)

24 Sec. 11-5.3. Procurement of vendor to verify eligibility
25 for assistance under Article V.

1 (a) No later than 60 days after the effective date of this
2 amendatory Act of the 97th General Assembly, the Chief
3 Procurement Officer for General Services, in consultation with
4 the Department of Healthcare and Family Services, shall conduct
5 and complete any procurement necessary to procure a vendor to
6 verify eligibility for assistance under Article V of this Code.
7 Such authority shall include procuring a vendor to assist the
8 Chief Procurement Officer in conducting the procurement. The
9 Chief Procurement Officer and the Department shall jointly
10 negotiate final contract terms with a vendor selected by the
11 Chief Procurement Officer. Within 30 days of selection of an
12 eligibility verification vendor, the Department of Healthcare
13 and Family Services shall enter into a contract with the
14 selected vendor. The Department of Healthcare and Family
15 Services and the Department of Human Services shall cooperate
16 with and provide any information requested by the Chief
17 Procurement Officer to conduct the procurement.

18 (b) Notwithstanding any other provision of law, any
19 procurement or contract necessary to comply with this Section
20 shall be exempt from: (i) the Illinois Procurement Code
21 pursuant to Section 1-10(h) of the Illinois Procurement Code,
22 except that bidders shall comply with the disclosure
23 requirement in Sections 50-10.5(a) through (d), 50-13, 50-35,
24 and 50-37 of the Illinois Procurement Code and a vendor awarded
25 a contract under this Section shall comply with Section 50-37
26 of the Procurement Code; (ii) any administrative rules of this

1 State pertaining to procurement or contract formation; and
2 (iii) any State or Department policies or procedures pertaining
3 to procurement, contract formation, contract award, and
4 Business Enterprise Program approval.

5 (c) Upon becoming operational, the contractor shall
6 conduct data matches using the name, date of birth, address,
7 and Social Security Number of each applicant and recipient
8 against public records to verify eligibility. The contractor,
9 upon preliminary determination that an enrollee is eligible or
10 ineligible, shall notify the Department. Within 20 business
11 days of such notification, the Department shall accept the
12 recommendation or reject it with a stated reason. The
13 Department shall retain final authority over eligibility
14 determinations. The contractor shall keep a record of all
15 preliminary determinations of ineligibility communicated to
16 the Department. Within 30 days of the end of each calendar
17 quarter, the Department and contractor shall file a joint
18 report on a quarterly basis to the Governor, the Speaker of the
19 House of Representatives, the Minority Leader of the House of
20 Representatives, the Senate President, and the Senate Minority
21 Leader. The report shall include, but shall not be limited to,
22 monthly recommendations of preliminary determinations of
23 eligibility or ineligibility communicated by the contractor,
24 the actions taken on those preliminary determinations by the
25 Department, and the stated reasons for those recommendations
26 that the Department rejected.

1 (d) An eligibility verification vendor contract shall be
2 awarded for an initial 2-year period with up to a maximum of 2
3 one-year renewal options. Nothing in this Section shall compel
4 the award of a contract to a vendor that fails to meet the
5 needs of the Department. A contract with a vendor to assist in
6 the procurement shall be awarded for a period of time not to
7 exceed 6 months.

8 (305 ILCS 5/11-13) (from Ch. 23, par. 11-13)

9 Sec. 11-13. Conditions For Receipt of Vendor Payments -
10 Limitation Period For Vendor Action - Penalty For Violation. A
11 vendor payment, as defined in Section 2-5 of Article II, shall
12 constitute payment in full for the goods or services covered
13 thereby. Acceptance of the payment by or in behalf of the
14 vendor shall bar him from obtaining, or attempting to obtain,
15 additional payment therefor from the recipient or any other
16 person. A vendor payment shall not, however, bar recovery of
17 the value of goods and services the obligation for which, under
18 the rules and regulations of the Illinois Department, is to be
19 met from the income and resources available to the recipient,
20 and in respect to which the vendor payment of the Illinois
21 Department or the local governmental unit represents
22 supplementation of such available income and resources.

23 Vendors seeking to enforce obligations of a governmental
24 unit or the Illinois Department for goods or services (1)
25 furnished to or in behalf of recipients and (2) subject to a

1 vendor payment as defined in Section 2-5, shall commence their
2 actions in the appropriate Circuit Court or the Court of
3 Claims, as the case may require, within one year next after the
4 cause of action accrued.

5 A cause of action accrues within the meaning of this
6 Section upon the following date:

7 (1) If the vendor can prove that he submitted a bill for
8 the service rendered to the Illinois Department or a
9 governmental unit within 180 days after ~~12 months of~~ the date
10 the service was rendered, then (a) upon the date the Illinois
11 Department or a governmental unit mails to the vendor
12 information that it is paying a bill in part or is refusing to
13 pay a bill in whole or in part, or (b) upon the date one year
14 following the date the vendor submitted such bill if the
15 Illinois Department or a governmental unit fails to mail to the
16 vendor such payment information within one year following the
17 date the vendor submitted the bill; or

18 (2) If the vendor cannot prove that he submitted a bill for
19 the service rendered within 180 days after ~~12 months of~~ the
20 date the service was rendered, then upon the date 12 months
21 following the date the vendor rendered the service to the
22 recipient.

23 In the case of long term care facilities, where the
24 Illinois Department initiates the monthly billing process for
25 the vendor, the cause of action shall accrue 12 months after
26 the last day of the month the service was rendered.

1 This paragraph governs only vendor payments as defined in
2 this Code and as limited by regulations of the Illinois
3 Department; it does not apply to goods or services purchased or
4 contracted for by a recipient under circumstances in which the
5 payment is to be made directly by the recipient.

6 Any vendor who accepts a vendor payment and who knowingly
7 obtains or attempts to obtain additional payment for the goods
8 or services covered by the vendor payment from the recipient or
9 any other person shall be guilty of a Class B misdemeanor.

10 (Source: P.A. 86-430.)

11 (305 ILCS 5/11-26) (from Ch. 23, par. 11-26)

12 Sec. 11-26. Recipient's abuse of medical care;
13 restrictions on access to medical care.

14 (a) When the Department determines, on the basis of
15 statistical norms and medical judgment, that a medical care
16 recipient has received medical services in excess of need and
17 with such frequency or in such a manner as to constitute an
18 abuse of the recipient's medical care privileges, the
19 recipient's access to medical care may be restricted.

20 (b) When the Department has determined that a recipient is
21 abusing his or her medical care privileges as described in this
22 Section, it may require that the recipient designate a primary
23 provider type of the recipient's own choosing to assume
24 responsibility for the recipient's care. For the purposes of
25 this subsection, "primary provider type" means a provider type

1 as determined by the Department ~~primary care provider, primary~~
2 ~~care pharmacy, primary dentist, primary podiatrist, or primary~~
3 ~~durable medical equipment provider.~~ Instead of requiring a
4 recipient to make a designation as provided in this subsection,
5 the Department, pursuant to rules adopted by the Department and
6 without regard to any choice of an entity that the recipient
7 might otherwise make, may initially designate a primary
8 provider type provided that the primary provider type is
9 willing to provide that care.

10 (c) When the Department has requested that a recipient
11 designate a primary provider type and the recipient fails or
12 refuses to do so, the Department may, after a reasonable period
13 of time, assign the recipient to a primary provider type of its
14 own choice and determination, provided such primary provider
15 type is willing to provide such care.

16 (d) When a recipient has been restricted to a designated
17 primary provider type, the recipient may change the primary
18 provider type:

19 (1) when the designated source becomes unavailable, as
20 the Department shall determine by rule; or

21 (2) when the designated primary provider type notifies
22 the Department that it wishes to withdraw from any
23 obligation as primary provider type; or

24 (3) in other situations, as the Department shall
25 provide by rule.

26 The Department shall, by rule, establish procedures for

1 providing medical or pharmaceutical services when the
2 designated source becomes unavailable or wishes to withdraw
3 from any obligation as primary provider type, shall, by rule,
4 take into consideration the need for emergency or temporary
5 medical assistance and shall ensure that the recipient has
6 continuous and unrestricted access to medical care from the
7 date on which such unavailability or withdrawal becomes
8 effective until such time as the recipient designates a primary
9 provider type or a primary provider type willing to provide
10 such care is designated by the Department consistent with
11 subsections (b) and (c) and such restriction becomes effective.

12 (e) Prior to initiating any action to restrict a
13 recipient's access to medical or pharmaceutical care, the
14 Department shall notify the recipient of its intended action.
15 Such notification shall be in writing and shall set forth the
16 reasons for and nature of the proposed action. In addition, the
17 notification shall:

18 (1) inform the recipient that (i) the recipient has a
19 right to designate a primary provider type of the
20 recipient's own choosing willing to accept such
21 designation and that the recipient's failure to do so
22 within a reasonable time may result in such designation
23 being made by the Department or (ii) the Department has
24 designated a primary provider type to assume
25 responsibility for the recipient's care; and

26 (2) inform the recipient that the recipient has a right

1 to appeal the Department's determination to restrict the
2 recipient's access to medical care and provide the
3 recipient with an explanation of how such appeal is to be
4 made. The notification shall also inform the recipient of
5 the circumstances under which unrestricted medical
6 eligibility shall continue until a decision is made on
7 appeal and that if the recipient chooses to appeal, the
8 recipient will be able to review the medical payment data
9 that was utilized by the Department to decide that the
10 recipient's access to medical care should be restricted.

11 (f) The Department shall, by rule or regulation, establish
12 procedures for appealing a determination to restrict a
13 recipient's access to medical care, which procedures shall, at
14 a minimum, provide for a reasonable opportunity to be heard
15 and, where the appeal is denied, for a written statement of the
16 reason or reasons for such denial.

17 (g) Except as otherwise provided in this subsection, when a
18 recipient has had his or her medical card restricted for 4 full
19 quarters (without regard to any period of ineligibility for
20 medical assistance under this Code, or any period for which the
21 recipient voluntarily terminates his or her receipt of medical
22 assistance, that may occur before the expiration of those 4
23 full quarters), the Department shall reevaluate the
24 recipient's medical usage to determine whether it is still in
25 excess of need and with such frequency or in such a manner as
26 to constitute an abuse of the receipt of medical assistance. If

1 it is still in excess of need, the restriction shall be
2 continued for another 4 full quarters. If it is no longer in
3 excess of need, the restriction shall be discontinued. If a
4 recipient's access to medical care has been restricted under
5 this Section and the Department then determines, either at
6 reevaluation or after the restriction has been discontinued, to
7 restrict the recipient's access to medical care a second or
8 subsequent time, the second or subsequent restriction may be
9 imposed for a period of more than 4 full quarters. If the
10 Department restricts a recipient's access to medical care for a
11 period of more than 4 full quarters, as determined by rule, the
12 Department shall reevaluate the recipient's medical usage
13 after the end of the restriction period rather than after the
14 end of 4 full quarters. The Department shall notify the
15 recipient, in writing, of any decision to continue the
16 restriction and the reason or reasons therefor. A "quarter",
17 for purposes of this Section, shall be defined as one of the
18 following 3-month periods of time: January-March, April-June,
19 July-September or October-December.

20 (h) In addition to any other recipient whose acquisition of
21 medical care is determined to be in excess of need, the
22 Department may restrict the medical care privileges of the
23 following persons:

24 (1) recipients found to have loaned or altered their
25 cards or misused or falsely represented medical coverage;

26 (2) recipients found in possession of blank or forged

1 prescription pads;

2 (3) recipients who knowingly assist providers in
3 rendering excessive services or defrauding the medical
4 assistance program.

5 The procedural safeguards in this Section shall apply to
6 the above individuals.

7 (i) Restrictions under this Section shall be in addition to
8 and shall not in any way be limited by or limit any actions
9 taken under Article VIII-A of this Code.

10 (Source: P.A. 96-1501, eff. 1-25-11.)

11 (305 ILCS 5/12-4.25) (from Ch. 23, par. 12-4.25)

12 Sec. 12-4.25. Medical assistance program; vendor
13 participation.

14 (A) The Illinois Department may deny, suspend, or terminate
15 the eligibility of any person, firm, corporation, association,
16 agency, institution or other legal entity to participate as a
17 vendor of goods or services to recipients under the medical
18 assistance program under Article V, or may exclude any such
19 person or entity from participation as such a vendor, and may
20 deny, suspend, or recover payments, if after reasonable notice
21 and opportunity for a hearing the Illinois Department finds:

22 (a) Such vendor is not complying with the Department's
23 policy or rules and regulations, or with the terms and
24 conditions prescribed by the Illinois Department in its
25 vendor agreement, which document shall be developed by the

1 Department as a result of negotiations with each vendor
2 category, including physicians, hospitals, long term care
3 facilities, pharmacists, optometrists, podiatrists and
4 dentists setting forth the terms and conditions applicable
5 to the participation of each vendor group in the program;
6 or

7 (b) Such vendor has failed to keep or make available
8 for inspection, audit or copying, after receiving a written
9 request from the Illinois Department, such records
10 regarding payments claimed for providing services. This
11 section does not require vendors to make available patient
12 records of patients for whom services are not reimbursed
13 under this Code; or

14 (c) Such vendor has failed to furnish any information
15 requested by the Department regarding payments for
16 providing goods or services; or

17 (d) Such vendor has knowingly made, or caused to be
18 made, any false statement or representation of a material
19 fact in connection with the administration of the medical
20 assistance program; or

21 (e) Such vendor has furnished goods or services to a
22 recipient which are (1) in excess of need ~~his or her needs~~,
23 (2) harmful ~~to the recipient~~, or (3) of grossly inferior
24 quality, all of such determinations to be based upon
25 competent medical judgment and evaluations; or

26 (f) The vendor; a person with management

1 responsibility for a vendor; an officer or person owning,
2 either directly or indirectly, 5% or more of the shares of
3 stock or other evidences of ownership in a corporate
4 vendor; an owner of a sole proprietorship which is a
5 vendor; or a partner in a partnership which is a vendor,
6 either:

7 (1) was previously terminated, suspended, or
8 excluded from participation in the Illinois medical
9 assistance program, or was terminated, suspended, or
10 excluded from participation in another state or
11 federal medical assistance or health care program ~~a~~
12 ~~medical assistance program in another state that is of~~
13 ~~the same kind as the program of medical assistance~~
14 ~~provided under Article V of this Code; or~~

15 (2) was a person with management responsibility
16 for a vendor previously terminated, suspended, or
17 excluded from participation in the Illinois medical
18 assistance program, or terminated, suspended, or
19 excluded from participation in another state or
20 federal ~~a~~ medical assistance or health care program ~~in~~
21 ~~another state that is of the same kind as the program~~
22 ~~of medical assistance provided under Article V of this~~
23 ~~Code,~~ during the time of conduct which was the basis
24 for that vendor's termination, suspension, or
25 exclusion; or

26 (3) was an officer, or person owning, either

1 directly or indirectly, 5% or more of the shares of
2 stock or other evidences of ownership in a corporate or
3 limited liability company vendor previously
4 terminated, suspended, or excluded from participation
5 in the Illinois medical assistance program, or
6 terminated, suspended, or excluded from participation
7 in a state or federal medical assistance or health care
8 program ~~in another state that is of the same kind as~~
9 ~~the program of medical assistance provided under~~
10 ~~Article V of this Code,~~ during the time of conduct
11 which was the basis for that vendor's termination, suspension,
12 or exclusion; or

13 (4) was an owner of a sole proprietorship or
14 partner of a partnership previously terminated, suspended,
15 or excluded from participation in the
16 Illinois medical assistance program, or terminated, suspended,
17 or excluded from participation in a state or
18 federal medical assistance or health care program ~~in~~
19 ~~another state that is of the same kind as the program~~
20 ~~of medical assistance provided under Article V of this~~
21 ~~Code,~~ during the time of conduct which was the basis
22 for that vendor's termination, suspension, or
23 exclusion; or

24 (f-1) Such vendor has a delinquent debt owed to the
25 Illinois Department; or

26 (g) The vendor; a person with management

1 responsibility for a vendor; an officer or person owning,
2 either directly or indirectly, 5% or more of the shares of
3 stock or other evidences of ownership in a corporate or
4 limited liability company vendor; an owner of a sole
5 proprietorship which is a vendor; or a partner in a
6 partnership which is a vendor, either:

7 (1) has engaged in practices prohibited by
8 applicable federal or State law or regulation ~~relating~~
9 ~~to the medical assistance program~~; or

10 (2) was a person with management responsibility
11 for a vendor at the time that such vendor engaged in
12 practices prohibited by applicable federal or State
13 law or regulation ~~relating to the medical assistance~~
14 ~~program~~; or

15 (3) was an officer, or person owning, either
16 directly or indirectly, 5% or more of the shares of
17 stock or other evidences of ownership in a vendor at
18 the time such vendor engaged in practices prohibited by
19 applicable federal or State law or regulation ~~relating~~
20 ~~to the medical assistance program~~; or

21 (4) was an owner of a sole proprietorship or
22 partner of a partnership which was a vendor at the time
23 such vendor engaged in practices prohibited by
24 applicable federal or State law or regulation ~~relating~~
25 ~~to the medical assistance program~~; or

26 (h) The direct or indirect ownership of the vendor

1 (including the ownership of a vendor that is a sole
2 proprietorship, a partner's interest in a vendor that is a
3 partnership, or ownership of 5% or more of the shares of
4 stock or other evidences of ownership in a corporate
5 vendor) has been transferred by an individual who is
6 terminated, suspended, or excluded or barred from
7 participating as a vendor to the individual's spouse,
8 child, brother, sister, parent, grandparent, grandchild,
9 uncle, aunt, niece, nephew, cousin, or relative by
10 marriage.

11 (A-5) The Illinois Department may deny, suspend, or
12 terminate the eligibility of any person, firm, corporation,
13 association, agency, institution, or other legal entity to
14 participate as a vendor of goods or services to recipients
15 under the medical assistance program under Article V, or may
16 exclude any such person or entity from participation as such a
17 vendor, if, after reasonable notice and opportunity for a
18 hearing, the Illinois Department finds that the vendor; a
19 person with management responsibility for a vendor; an officer
20 or person owning, either directly or indirectly, 5% or more of
21 the shares of stock or other evidences of ownership in a
22 corporate vendor; an owner of a sole proprietorship that is a
23 vendor; or a partner in a partnership that is a vendor has been
24 convicted of an ~~a felony~~ offense based on fraud or willful
25 misrepresentation related to any of the following:

26 (1) The medical assistance program under Article V of

1 this Code.

2 (2) A medical assistance or health care program in
3 another state ~~that is of the same kind as the program of~~
4 ~~medical assistance provided under Article V of this Code.~~

5 (3) The Medicare program under Title XVIII of the
6 Social Security Act.

7 (4) The provision of health care services.

8 (5) A violation of this Code, as provided in Article
9 VIII A, or another state or federal medical assistance
10 program or health care program.

11 (A-10) The Illinois Department may deny, suspend, or
12 terminate the eligibility of any person, firm, corporation,
13 association, agency, institution, or other legal entity to
14 participate as a vendor of goods or services to recipients
15 under the medical assistance program under Article V, or may
16 exclude any such person or entity from participation as such a
17 vendor, if, after reasonable notice and opportunity for a
18 hearing, the Illinois Department finds that (i) the vendor,
19 (ii) a person with management responsibility for a vendor,
20 (iii) an officer or person owning, either directly or
21 indirectly, 5% or more of the shares of stock or other
22 evidences of ownership in a corporate vendor, (iv) an owner of
23 a sole proprietorship that is a vendor, or (v) a partner in a
24 partnership that is a vendor has been convicted of an a-felony
25 offense related to any of the following:

26 (1) Murder.

1 (2) A Class X felony under the Criminal Code of 1961.

2 (3) Sexual misconduct that may subject recipients to an
3 undue risk of harm.

4 (4) A criminal offense that may subject recipients to
5 an undue risk of harm.

6 (5) A crime of fraud or dishonesty.

7 (6) A crime involving a controlled substance.

8 (7) A misdemeanor relating to fraud, theft,
9 embezzlement, breach of fiduciary responsibility, or other
10 financial misconduct related to a health care program.

11 (A-15) The Illinois Department may deny the eligibility of
12 any person, firm, corporation, association, agency,
13 institution, or other legal entity to participate as a vendor
14 of goods or services to recipients under the medical assistance
15 program under Article V if, after reasonable notice and
16 opportunity for a hearing, the Illinois Department finds:

17 (1) The applicant or any person with management
18 responsibility for the applicant; an officer or member of
19 the board of directors of an applicant; an entity owning
20 (directly or indirectly) 5% or more of the shares of stock
21 or other evidences of ownership in a corporate vendor
22 applicant; an owner of a sole proprietorship applicant; a
23 partner in a partnership applicant; or a technical or other
24 advisor to an applicant has a debt owed to the Illinois
25 Department, and no payment arrangements acceptable to the
26 Illinois Department have been made by the applicant.

1 (2) The applicant or any person with management
2 responsibility for the applicant; an officer or member of
3 the board of directors of an applicant; an entity owning
4 (directly or indirectly) 5% or more of the shares of stock
5 or other evidences of ownership in a corporate vendor
6 applicant; an owner of a sole proprietorship applicant; a
7 partner in a partnership vendor applicant; or a technical
8 or other advisor to an applicant was (i) a person with
9 management responsibility, (ii) an officer or member of the
10 board of directors of an applicant, (iii) an entity owning
11 (directly or indirectly) 5% or more of the shares of stock
12 or other evidences of ownership in a corporate vendor, (iv)
13 an owner of a sole proprietorship, (v) a partner in a
14 partnership vendor, (vi) a technical or other advisor to a
15 vendor, during a period of time where the conduct of that
16 vendor resulted in a debt owed to the Illinois Department,
17 and no payment arrangements acceptable to the Illinois
18 Department have been made by that vendor.

19 (3) There is a credible allegation of the use,
20 transfer, or lease of assets of any kind to an applicant
21 from a current or prior vendor who has a debt owed to the
22 Illinois Department, no payment arrangements acceptable to
23 the Illinois Department have been made by that vendor or
24 the vendor's alternate payee, and the applicant knows or
25 should have known of such debt.

26 (4) There is a credible allegation of a transfer of

1 management responsibilities, or direct or indirect
2 ownership, to an applicant from a current or prior vendor
3 who has a debt owed to the Illinois Department, and no
4 payment arrangements acceptable to the Illinois Department
5 have been made by that vendor or the vendor's alternate
6 payee, and the applicant knows or should have known of such
7 debt.

8 (5) There is a credible allegation of the use,
9 transfer, or lease of assets of any kind to an applicant
10 who is a spouse, child, brother, sister, parent,
11 grandparent, grandchild, uncle, aunt, niece, relative by
12 marriage, nephew, cousin, or relative of a current or prior
13 vendor who has a debt owed to the Illinois Department and
14 no payment arrangements acceptable to the Illinois
15 Department have been made.

16 (6) There is a credible allegation that the applicant's
17 previous affiliations with a provider of medical services
18 that has an uncollected debt, a provider that has been or
19 is subject to a payment suspension under a federal health
20 care program, or a provider that has been previously
21 excluded from participation in the medical assistance
22 program, poses a risk of fraud, waste, or abuse to the
23 Illinois Department.

24 As used in this subsection, "credible allegation" is
25 defined to include an allegation from any source, including,
26 but not limited to, fraud hotline complaints, claims data

1 mining, patterns identified through provider audits, civil
2 actions filed under the False Claims Act, and law enforcement
3 investigations. An allegation is considered to be credible when
4 it has indicia of reliability.

5 (B) The Illinois Department shall deny, suspend or
6 terminate the eligibility of any person, firm, corporation,
7 association, agency, institution or other legal entity to
8 participate as a vendor of goods or services to recipients
9 under the medical assistance program under Article V, or may
10 exclude any such person or entity from participation as such a
11 vendor:

12 (1) immediately, if such vendor is not properly
13 licensed, certified, or authorized;

14 (2) within 30 days of the date when such vendor's
15 professional license, certification or other authorization
16 has been refused renewal, restricted, ~~or has been~~ revoked,
17 suspended, or otherwise terminated; or

18 (3) if such vendor has been convicted of a violation of
19 this Code, as provided in Article VIIIA.

20 (C) Upon termination, suspension, or exclusion of a vendor
21 of goods or services from participation in the medical
22 assistance program authorized by this Article, a person with
23 management responsibility for such vendor during the time of
24 any conduct which served as the basis for that vendor's
25 termination, suspension, or exclusion is barred from
26 participation in the medical assistance program.

1 Upon termination, suspension, or exclusion of a corporate
2 vendor, the officers and persons owning, directly or
3 indirectly, 5% or more of the shares of stock or other
4 evidences of ownership in the vendor during the time of any
5 conduct which served as the basis for that vendor's
6 termination, suspension, or exclusion are barred from
7 participation in the medical assistance program. A person who
8 owns, directly or indirectly, 5% or more of the shares of stock
9 or other evidences of ownership in a terminated, suspended, or
10 excluded ~~corporate~~ vendor may not transfer his or her ownership
11 interest in that vendor to his or her spouse, child, brother,
12 sister, parent, grandparent, grandchild, uncle, aunt, niece,
13 nephew, cousin, or relative by marriage.

14 Upon termination, suspension, or exclusion of a sole
15 proprietorship or partnership, the owner or partners during the
16 time of any conduct which served as the basis for that vendor's
17 termination, suspension, or exclusion are barred from
18 participation in the medical assistance program. The owner of a
19 terminated, suspended, or excluded vendor that is a sole
20 proprietorship, and a partner in a terminated, suspended, or
21 excluded vendor that is a partnership, may not transfer his or
22 her ownership or partnership interest in that vendor to his or
23 her spouse, child, brother, sister, parent, grandparent,
24 grandchild, uncle, aunt, niece, nephew, cousin, or relative by
25 marriage.

26 A person who owns, directly or indirectly, 5% or more of

1 the shares of stock or other evidences of ownership in a
2 corporate or limited liability company vendor who owes a debt
3 to the Department, if that vendor has not made payment
4 arrangements acceptable to the Department, shall not transfer
5 his or her ownership interest in that vendor, or vendor assets
6 of any kind, to his or her spouse, child, brother, sister,
7 parent, grandparent, grandchild, uncle, aunt, niece, nephew,
8 cousin, or relative by marriage.

9 Rules adopted by the Illinois Department to implement these
10 provisions shall specifically include a definition of the term
11 "management responsibility" as used in this Section. Such
12 definition shall include, but not be limited to, typical job
13 titles, and duties and descriptions which will be considered as
14 within the definition of individuals with management
15 responsibility for a provider.

16 A vendor or a prior vendor who has been terminated,
17 excluded, or suspended from the medical assistance program, or
18 from another state or federal medical assistance or health care
19 program, and any individual currently or previously barred from
20 the medical assistance program, or from another state or
21 federal medical assistance or health care program, as a result
22 of being an officer or a person owning, directly, or
23 indirectly, 5% or more of the shares of stock or other
24 evidences of ownership in a corporate or limited liability
25 company vendor during the time of any conduct which served as
26 the basis for that vendor's termination, suspension, or

1 exclusion, may be required to post a surety bond as part of a
2 condition of enrollment or participation in the medical
3 assistance program. The Illinois Department shall establish,
4 by rule, the criteria and requirements for determining when a
5 surety bond must be posted and the value of the bond.

6 A vendor or a prior vendor who has a debt owed to the
7 Illinois Department and any individual currently or previously
8 barred from the medical assistance program, or from another
9 state or federal medical assistance or health care program, as
10 a result of being an officer or a person owning, directly or
11 indirectly, 5% or more of the shares of stock or other
12 evidences of ownership in that corporate or limited liability
13 company vendor during the time of any conduct which served as
14 the basis for the debt, may be required to post a surety bond
15 as part of a condition of enrollment or participation in the
16 medical assistance program. The Illinois Department shall
17 establish, by rule, the criteria and requirements for
18 determining when a surety bond must be posted and the value of
19 the bond.

20 (D) If a vendor has been suspended from the medical
21 assistance program under Article V of the Code, the Director
22 may require that such vendor correct any deficiencies which
23 served as the basis for the suspension. The Director shall
24 specify in the suspension order a specific period of time,
25 which shall not exceed one year from the date of the order,
26 during which a suspended vendor shall not be eligible to

1 participate. At the conclusion of the period of suspension the
2 Director shall reinstate such vendor, unless he finds that such
3 vendor has not corrected deficiencies upon which the suspension
4 was based.

5 If a vendor has been terminated, suspended, or excluded
6 from the medical assistance program under Article V, such
7 vendor shall be barred from participation for at least one
8 year, except that if a vendor has been terminated, suspended,
9 or excluded based on a conviction of a violation of Article
10 VIIIA or a conviction of a felony based on fraud or a willful
11 misrepresentation related to (i) the medical assistance
12 program under Article V, (ii) a federal or another state's
13 medical assistance or health care program ~~in another state that~~
14 ~~is of the kind provided under Article V,~~ (iii) the Medicare
15 ~~program under Title XVIII of the Social Security Act,~~ or (iii)
16 ~~(iv)~~ the provision of health care services, then the vendor
17 shall be barred from participation for 5 years or for the
18 length of the vendor's sentence for that conviction, whichever
19 is longer. At the end of one year a vendor who has been
20 terminated, suspended, or excluded may apply for reinstatement
21 to the program. Upon proper application to be reinstated such
22 vendor may be deemed eligible by the Director providing that
23 such vendor meets the requirements for eligibility under this
24 Code. If such vendor is deemed not eligible for reinstatement,
25 he shall be barred from again applying for reinstatement for
26 one year from the date his application for reinstatement is

1 denied.

2 A vendor whose termination, suspension, or exclusion from
3 participation in the Illinois medical assistance program under
4 Article V was based solely on an action by a governmental
5 entity other than the Illinois Department may, upon
6 reinstatement by that governmental entity or upon reversal of
7 the termination, suspension, or exclusion, apply for
8 rescission of the termination, suspension, or exclusion from
9 participation in the Illinois medical assistance program. Upon
10 proper application for rescission, the vendor may be deemed
11 eligible by the Director if the vendor meets the requirements
12 for eligibility under this Code.

13 If a vendor has been terminated, suspended, or excluded and
14 reinstated to the medical assistance program under Article V
15 and the vendor is terminated, suspended, or excluded a second
16 or subsequent time from the medical assistance program, the
17 vendor shall be barred from participation for at least 2 years,
18 except that if a vendor has been terminated, suspended, or
19 excluded a second time based on a conviction of a violation of
20 Article VIII A or a conviction of a felony based on fraud or a
21 willful misrepresentation related to (i) the medical
22 assistance program under Article V, (ii) a federal or another
23 state's medical assistance or health care program ~~in another~~
24 ~~state that is of the kind provided under Article V,~~ (iii) the
25 ~~Medicare program under Title XVIII of the Social Security Act,~~
26 or (iii) ~~(iv)~~ the provision of health care services, then the

1 vendor shall be barred from participation for life. At the end
2 of 2 years, a vendor who has been terminated, suspended, or
3 excluded may apply for reinstatement to the program. Upon
4 application to be reinstated, the vendor may be deemed eligible
5 if the vendor meets the requirements for eligibility under this
6 Code. If the vendor is deemed not eligible for reinstatement,
7 the vendor shall be barred from again applying for
8 reinstatement for 2 years from the date the vendor's
9 application for reinstatement is denied.

10 (E) The Illinois Department may recover money improperly or
11 erroneously paid, or overpayments, either by setoff, crediting
12 against future billings or by requiring direct repayment to the
13 Illinois Department. The Illinois Department may suspend or
14 deny payment, in whole or in part, if such payment would be
15 improper or erroneous or would otherwise result in overpayment.

16 (1) Payments may be suspended, denied, or recovered
17 from a vendor or alternate payee: (i) for services rendered
18 in violation of the Illinois Department's provider
19 notices, statutes, rules, and regulations; (ii) for
20 services rendered in violation of the terms and conditions
21 prescribed by the Illinois Department in its vendor
22 agreement; (iii) for any vendor who fails to grant the
23 Office of Inspector General timely access to full and
24 complete records, including, but not limited to, records
25 relating to recipients under the medical assistance
26 program for the most recent 6 years, in accordance with

1 Section 140.28 of Title 89 of the Illinois Administrative
2 Code, and other information for the purpose of audits,
3 investigations, or other program integrity functions,
4 after reasonable written request by the Inspector General;
5 this subsection (E) does not require vendors to make
6 available the medical records of patients for whom services
7 are not reimbursed under this Code or to provide access to
8 medical records more than 6 years old; (iv) when the vendor
9 has knowingly made, or caused to be made, any false
10 statement or representation of a material fact in
11 connection with the administration of the medical
12 assistance program; or (v) when the vendor previously
13 rendered services while terminated, suspended, or excluded
14 from participation in the medical assistance program or
15 while terminated or excluded from participation in another
16 state or federal medical assistance or health care program.

17 (2) Notwithstanding any other provision of law, if a
18 vendor has the same taxpayer identification number
19 (assigned under Section 6109 of the Internal Revenue Code
20 of 1986) as is assigned to a vendor with past-due financial
21 obligations to the Illinois Department, the Illinois
22 Department may make any necessary adjustments to payments
23 to that vendor in order to satisfy any past-due
24 obligations, regardless of whether the vendor is assigned a
25 different billing number under the medical assistance
26 program.

1 If the Illinois Department establishes through an
2 administrative hearing that the overpayments resulted from the
3 vendor or alternate payee knowingly ~~willfully~~ making, using, or
4 causing to be made or used, a false record or statement to
5 obtain payment or other benefit from ~~or misrepresentation of a~~
6 ~~material fact in connection with billings and payments under~~
7 the medical assistance program under Article V, the Department
8 may recover interest on the amount of the payment or other
9 benefit ~~overpayments~~ at the rate of 5% per annum. In addition
10 to any other penalties that may be prescribed by law, such a
11 vendor or alternate payee shall be subject to civil penalties
12 consisting of an amount not to exceed 3 times the amount of
13 payment or other benefit resulting from each such false record
14 or statement, and the sum of \$2,000 for each such false record
15 or statement for payment or other benefit. For purposes of this
16 paragraph, "knowingly" "~~willfully~~" means that a vendor or
17 alternate payee with respect to information: (i) has ~~person~~
18 ~~makes a statement or representation with~~ actual knowledge of
19 the information, (ii) acts in deliberate ignorance of the truth
20 or falsity of the information, or (iii) acts in reckless
21 disregard of the truth or falsity of the information. No proof
22 of specific intent to defraud is required. ~~that it was false,~~
23 ~~or makes a statement or representation with knowledge of facts~~
24 ~~or information that would cause one to be aware that the~~
25 ~~statement or representation was false when made.~~

26 (F) The Illinois Department may withhold payments to any

1 vendor or alternate payee prior to or during the pendency of
2 any audit or proceeding under this Section, and through the
3 pendency of any administrative appeal or administrative review
4 by any court proceeding. The Illinois Department shall state by
5 rule with as much specificity as practicable the conditions
6 under which payments will not be withheld ~~during the pendency~~
7 ~~of any proceeding~~ under this Section. Payments may be denied
8 for bills submitted with service dates occurring during the
9 pendency of a proceeding, after a final decision has been
10 rendered, or after the conclusion of any administrative appeal,
11 where the final administrative decision is to terminate,
12 exclude, or suspend eligibility to participate in the medical
13 assistance program. The Illinois Department shall state by rule
14 with as much specificity as practicable the conditions under
15 which payments will not be denied for such bills. The Illinois
16 Department shall state by rule a process and criteria by which
17 a vendor or alternate payee may request full or partial release
18 of payments withheld under this subsection. The Department must
19 complete a proceeding under this Section in a timely manner.

20 Notwithstanding recovery allowed under subsection (E) or
21 this subsection (F), the Illinois Department may withhold
22 payments to any vendor or alternate payee who is not properly
23 licensed, certified, or in compliance with State or federal
24 agency regulations. Payments may be denied for bills submitted
25 with service dates occurring during the period of time that a
26 vendor is not properly licensed, certified, or in compliance

1 with State or federal regulations. Facilities licensed under
2 the Nursing Home Care Act shall have payments denied or
3 withheld pursuant to subsection (I) of this Section.

4 (F-5) The Illinois Department may temporarily withhold
5 payments to a vendor or alternate payee if any of the following
6 individuals have been indicted or otherwise charged under a law
7 of the United States or this or any other state with an a
8 ~~felony~~ offense that is based on alleged fraud or willful
9 misrepresentation on the part of the individual related to (i)
10 the medical assistance program under Article V of this Code,
11 (ii) a federal or another state's medical assistance or health
12 care program ~~provided in another state which is of the kind~~
13 ~~provided under Article V of this Code, (iii) the Medicare~~
14 ~~program under Title XVIII of the Social Security Act, or (iii)~~
15 ~~(iv)~~ the provision of health care services:

16 (1) If the vendor or alternate payee is a corporation:
17 an officer of the corporation or an individual who owns,
18 either directly or indirectly, 5% or more of the shares of
19 stock or other evidence of ownership of the corporation.

20 (2) If the vendor is a sole proprietorship: the owner
21 of the sole proprietorship.

22 (3) If the vendor or alternate payee is a partnership:
23 a partner in the partnership.

24 (4) If the vendor or alternate payee is any other
25 business entity authorized by law to transact business in
26 this State: an officer of the entity or an individual who

1 owns, either directly or indirectly, 5% or more of the
2 evidences of ownership of the entity.

3 If the Illinois Department withholds payments to a vendor
4 or alternate payee under this subsection, the Department shall
5 not release those payments to the vendor or alternate payee
6 while any criminal proceeding related to the indictment or
7 charge is pending unless the Department determines that there
8 is good cause to release the payments before completion of the
9 proceeding. If the indictment or charge results in the
10 individual's conviction, the Illinois Department shall retain
11 all withheld payments, which shall be considered forfeited to
12 the Department. If the indictment or charge does not result in
13 the individual's conviction, the Illinois Department shall
14 release to the vendor or alternate payee all withheld payments.

15 (F-10) If the Illinois Department establishes that the
16 vendor or alternate payee owes a debt to the Illinois
17 Department, and the vendor or alternate payee subsequently
18 fails to pay or make satisfactory payment arrangements with the
19 Illinois Department for the debt owed, the Illinois Department
20 may seek all remedies available under the law of this State to
21 recover the debt, including, but not limited to, wage
22 garnishment or the filing of claims or liens against the vendor
23 or alternate payee.

24 (F-15) Enforcement of judgment.

25 (1) Any fine, recovery amount, other sanction, or costs
26 imposed, or part of any fine, recovery amount, other

1 sanction, or cost imposed, remaining unpaid after the
2 exhaustion of or the failure to exhaust judicial review
3 procedures under the Illinois Administrative Review Law is
4 a debt due and owing the State and may be collected using
5 all remedies available under the law.

6 (2) After expiration of the period in which judicial
7 review under the Illinois Administrative Review Law may be
8 sought for a final administrative decision, unless stayed
9 by a court of competent jurisdiction, the findings,
10 decision, and order of the Director may be enforced in the
11 same manner as a judgment entered by a court of competent
12 jurisdiction.

13 (3) In any case in which any person or entity has
14 failed to comply with a judgment ordering or imposing any
15 fine or other sanction, any expenses incurred by the
16 Illinois Department to enforce the judgment, including,
17 but not limited to, attorney's fees, court costs, and costs
18 related to property demolition or foreclosure, after they
19 are fixed by a court of competent jurisdiction or the
20 Director, shall be a debt due and owing the State and may
21 be collected in accordance with applicable law. Prior to
22 any expenses being fixed by a final administrative decision
23 pursuant to this subsection (F-15), the Illinois
24 Department shall provide notice to the individual or entity
25 that states that the individual or entity shall appear at a
26 hearing before the administrative hearing officer to

1 determine whether the individual or entity has failed to
2 comply with the judgment. The notice shall set the date for
3 such a hearing, which shall not be less than 7 days from
4 the date that notice is served. If notice is served by
5 mail, the 7-day period shall begin to run on the date that
6 the notice was deposited in the mail.

7 (4) Upon being recorded in the manner required by
8 Article XII of the Code of Civil Procedure or by the
9 Uniform Commercial Code, a lien shall be imposed on the
10 real estate or personal estate, or both, of the individual
11 or entity in the amount of any debt due and owing the State
12 under this Section. The lien may be enforced in the same
13 manner as a judgment of a court of competent jurisdiction.
14 A lien shall attach to all property and assets of such
15 person, firm, corporation, association, agency,
16 institution, or other legal entity until the judgment is
17 satisfied.

18 (5) The Director may set aside any judgment entered by
19 default and set a new hearing date upon a petition filed at
20 any time (i) if the petitioner's failure to appear at the
21 hearing was for good cause, or (ii) if the petitioner
22 established that the Department did not provide proper
23 service of process. If any judgment is set aside pursuant
24 to this paragraph (5), the hearing officer shall have
25 authority to enter an order extinguishing any lien which
26 has been recorded for any debt due and owing the Illinois

1 Department as a result of the vacated default judgment.

2 (G) The provisions of the Administrative Review Law, as now
3 or hereafter amended, and the rules adopted pursuant thereto,
4 shall apply to and govern all proceedings for the judicial
5 review of final administrative decisions of the Illinois
6 Department under this Section. The term "administrative
7 decision" is defined as in Section 3-101 of the Code of Civil
8 Procedure.

9 (G-5) Vendors who pose a risk of fraud, waste, abuse, or
10 harm ~~Non-emergency transportation.~~

11 (1) Notwithstanding any other provision in this
12 Section, ~~for non-emergency transportation vendors,~~ the
13 Department may terminate, suspend, or exclude vendors who
14 pose a risk of fraud, waste, abuse, or harm ~~the vendor~~ from
15 participation in the medical assistance program prior to an
16 evidentiary hearing but after reasonable notice and
17 opportunity to respond as established by the Department by
18 rule.

19 (2) Vendors who pose a risk of fraud, waste, abuse, or
20 harm ~~of non-emergency medical transportation services, as~~
21 ~~defined by the Department by rule,~~ shall submit to a
22 fingerprint-based criminal background check on current and
23 future information available in the State system and
24 current information available through the Federal Bureau
25 of Investigation's system by submitting all necessary fees
26 and information in the form and manner prescribed by the

1 Department of State Police. The following individuals
2 shall be subject to the check:

3 (A) In the case of a vendor that is a corporation,
4 every shareholder who owns, directly or indirectly, 5%
5 or more of the outstanding shares of the corporation.

6 (B) In the case of a vendor that is a partnership,
7 every partner.

8 (C) In the case of a vendor that is a sole
9 proprietorship, the sole proprietor.

10 (D) Each officer or manager of the vendor.

11 Each such vendor shall be responsible for payment of
12 the cost of the criminal background check.

13 (3) Vendors who pose a risk of fraud, waste, abuse, or
14 harm of non-emergency medical transportation services may
15 be required to post a surety bond. The Department shall
16 establish, by rule, the criteria and requirements for
17 determining when a surety bond must be posted and the value
18 of the bond.

19 (4) The Department, or its agents, may refuse to accept
20 requests for authorization from specific vendors who pose a
21 risk of fraud, waste, abuse, or harm non-emergency
22 transportation authorizations, including prior-approval
23 and post-approval requests, ~~for a specific non-emergency~~
24 ~~transportation vendor~~ if:

25 (A) the Department has initiated a notice of
26 termination, suspension, or exclusion of the vendor

1 from participation in the medical assistance program;
2 or

3 (B) the Department has issued notification of its
4 withholding of payments pursuant to subsection (F-5)
5 of this Section; or

6 (C) the Department has issued a notification of its
7 withholding of payments due to reliable evidence of
8 fraud or willful misrepresentation pending
9 investigation.

10 (5) As used in this subsection, the following terms are
11 defined as follows:

12 (A) "Fraud" means an intentional deception or
13 misrepresentation made by a person with the knowledge
14 that the deception could result in some unauthorized
15 benefit to himself or herself or some other person. It
16 includes any act that constitutes fraud under
17 applicable federal or State law.

18 (B) "Abuse" means provider practices that are
19 inconsistent with sound fiscal, business, or medical
20 practices and that result in an unnecessary cost to the
21 medical assistance program or in reimbursement for
22 services that are not medically necessary or that fail
23 to meet professionally recognized standards for health
24 care. It also includes recipient practices that result
25 in unnecessary cost to the medical assistance program.
26 Abuse does not include diagnostic or therapeutic

1 measures conducted primarily as a safeguard against
2 possible vendor liability.

3 (C) "Waste" means the unintentional misuse of
4 medical assistance resources, resulting in unnecessary
5 cost to the medical assistance program. Waste does not
6 include diagnostic or therapeutic measures conducted
7 primarily as a safeguard against possible vendor
8 liability.

9 (D) "Harm" means physical, mental, or monetary
10 damage to recipients or to the medical assistance
11 program.

12 (G-6) The Illinois Department, upon making a determination
13 based upon information in the possession of the Illinois
14 Department that continuation of participation in the medical
15 assistance program by a vendor would constitute an immediate
16 danger to the public, may immediately suspend such vendor's
17 participation in the medical assistance program without a
18 hearing. In instances in which the Illinois Department
19 immediately suspends the medical assistance program
20 participation of a vendor under this Section, a hearing upon
21 the vendor's participation must be convened by the Illinois
22 Department within 15 days after such suspension and completed
23 without appreciable delay. Such hearing shall be held to
24 determine whether to recommend to the Director that the
25 vendor's medical assistance program participation be denied,
26 terminated, suspended, placed on provisional status, or

1 reinstated. In the hearing, any evidence relevant to the vendor
2 constituting an immediate danger to the public may be
3 introduced against such vendor; provided, however, that the
4 vendor, or his or her counsel, shall have the opportunity to
5 discredit, impeach, and submit evidence rebutting such
6 evidence.

7 (H) Nothing contained in this Code shall in any way limit
8 or otherwise impair the authority or power of any State agency
9 responsible for licensing of vendors.

10 (I) Based on a finding of noncompliance on the part of a
11 nursing home with any requirement for certification under Title
12 XVIII or XIX of the Social Security Act (42 U.S.C. Sec. 1395 et
13 seq. or 42 U.S.C. Sec. 1396 et seq.), the Illinois Department
14 may impose one or more of the following remedies after notice
15 to the facility:

16 (1) Termination of the provider agreement.

17 (2) Temporary management.

18 (3) Denial of payment for new admissions.

19 (4) Civil money penalties.

20 (5) Closure of the facility in emergency situations or
21 transfer of residents, or both.

22 (6) State monitoring.

23 (7) Denial of all payments when the U.S. Department of
24 Health and Human Services ~~Health Care Finance~~
25 ~~Administration~~ has imposed this sanction.

26 The Illinois Department shall by rule establish criteria

1 governing continued payments to a nursing facility subsequent
2 to termination of the facility's provider agreement if, in the
3 sole discretion of the Illinois Department, circumstances
4 affecting the health, safety, and welfare of the facility's
5 residents require those continued payments. The Illinois
6 Department may condition those continued payments on the
7 appointment of temporary management, sale of the facility to
8 new owners or operators, or other arrangements that the
9 Illinois Department determines best serve the needs of the
10 facility's residents.

11 Except in the case of a facility that has a right to a
12 hearing on the finding of noncompliance before an agency of the
13 federal government, a facility may request a hearing before a
14 State agency on any finding of noncompliance within 60 days
15 after the notice of the intent to impose a remedy. Except in
16 the case of civil money penalties, a request for a hearing
17 shall not delay imposition of the penalty. The choice of
18 remedies is not appealable at a hearing. The level of
19 noncompliance may be challenged only in the case of a civil
20 money penalty. The Illinois Department shall provide by rule
21 for the State agency that will conduct the evidentiary
22 hearings.

23 The Illinois Department may collect interest on unpaid
24 civil money penalties.

25 The Illinois Department may adopt all rules necessary to
26 implement this subsection (I).

1 (J) The Illinois Department, by rule, may permit individual
2 practitioners to designate that Department payments that may be
3 due the practitioner be made to an alternate payee or alternate
4 payees.

5 (a) Such alternate payee or alternate payees shall be
6 required to register as an alternate payee in the Medical
7 Assistance Program with the Illinois Department.

8 (b) If a practitioner designates an alternate payee,
9 the alternate payee and practitioner shall be jointly and
10 severally liable to the Department for payments made to the
11 alternate payee. Pursuant to subsection (E) of this
12 Section, any Department action to suspend or deny payment
13 or recover money or overpayments from an alternate payee
14 shall be subject to an administrative hearing.

15 (c) Registration as an alternate payee or alternate
16 payees in the Illinois Medical Assistance Program shall be
17 conditional. At any time, the Illinois Department may deny
18 or cancel any alternate payee's registration in the
19 Illinois Medical Assistance Program without cause. Any
20 such denial or cancellation is not subject to an
21 administrative hearing.

22 (d) The Illinois Department may seek a revocation of
23 any alternate payee, and all owners, officers, and
24 individuals with management responsibility for such
25 alternate payee shall be permanently prohibited from
26 participating as an owner, an officer, or an individual

1 with management responsibility with an alternate payee in
2 the Illinois Medical Assistance Program, if after
3 reasonable notice and opportunity for a hearing the
4 Illinois Department finds that:

5 (1) the alternate payee is not complying with the
6 Department's policy or rules and regulations, or with
7 the terms and conditions prescribed by the Illinois
8 Department in its alternate payee registration
9 agreement; or

10 (2) the alternate payee has failed to keep or make
11 available for inspection, audit, or copying, after
12 receiving a written request from the Illinois
13 Department, such records regarding payments claimed as
14 an alternate payee; or

15 (3) the alternate payee has failed to furnish any
16 information requested by the Illinois Department
17 regarding payments claimed as an alternate payee; or

18 (4) the alternate payee has knowingly made, or
19 caused to be made, any false statement or
20 representation of a material fact in connection with
21 the administration of the Illinois Medical Assistance
22 Program; or

23 (5) the alternate payee, a person with management
24 responsibility for an alternate payee, an officer or
25 person owning, either directly or indirectly, 5% or
26 more of the shares of stock or other evidences of

1 ownership in a corporate alternate payee, or a partner
2 in a partnership which is an alternate payee:

3 (a) was previously terminated, suspended, or
4 excluded from participation as a vendor in the
5 Illinois Medical Assistance Program, or was
6 previously revoked as an alternate payee in the
7 Illinois Medical Assistance Program, or was
8 terminated, suspended, or excluded from
9 participation as a vendor in a medical assistance
10 program in another state that is of the same kind
11 as the program of medical assistance provided
12 under Article V of this Code; or

13 (b) was a person with management
14 responsibility for a vendor previously terminated, suspended, or excluded
15 suspended, or excluded from participation as a
16 vendor in the Illinois Medical Assistance Program,
17 or was previously revoked as an alternate payee in
18 the Illinois Medical Assistance Program, or was
19 terminated, suspended, or excluded from
20 participation as a vendor in a medical assistance
21 program in another state that is of the same kind
22 as the program of medical assistance provided
23 under Article V of this Code, during the time of
24 conduct which was the basis for that vendor's
25 termination, suspension, or exclusion or alternate
26 payee's revocation; or

1 (c) was an officer, or person owning, either
2 directly or indirectly, 5% or more of the shares of
3 stock or other evidences of ownership in a
4 corporate vendor previously terminated, suspended,
5 or excluded from participation as a vendor in the
6 Illinois Medical Assistance Program, or was
7 previously revoked as an alternate payee in the
8 Illinois Medical Assistance Program, or was
9 terminated, suspended, or excluded from
10 participation as a vendor in a medical assistance
11 program in another state that is of the same kind
12 as the program of medical assistance provided
13 under Article V of this Code, during the time of
14 conduct which was the basis for that vendor's
15 termination, suspension, or exclusion; or

16 (d) was an owner of a sole proprietorship or
17 partner in a partnership previously terminated, suspended,
18 or excluded from participation as a
19 vendor in the Illinois Medical Assistance Program,
20 or was previously revoked as an alternate payee in
21 the Illinois Medical Assistance Program, or was
22 terminated, suspended, or excluded from
23 participation as a vendor in a medical assistance
24 program in another state that is of the same kind
25 as the program of medical assistance provided
26 under Article V of this Code, during the time of

1 conduct which was the basis for that vendor's
2 termination, suspension, or exclusion or alternate
3 payee's revocation; or

4 (6) the alternate payee, a person with management
5 responsibility for an alternate payee, an officer or
6 person owning, either directly or indirectly, 5% or
7 more of the shares of stock or other evidences of
8 ownership in a corporate alternate payee, or a partner
9 in a partnership which is an alternate payee:

10 (a) has engaged in conduct prohibited by
11 applicable federal or State law or regulation
12 relating to the Illinois Medical Assistance
13 Program; or

14 (b) was a person with management
15 responsibility for a vendor or alternate payee at
16 the time that the vendor or alternate payee engaged
17 in practices prohibited by applicable federal or
18 State law or regulation relating to the Illinois
19 Medical Assistance Program; or

20 (c) was an officer, or person owning, either
21 directly or indirectly, 5% or more of the shares of
22 stock or other evidences of ownership in a vendor
23 or alternate payee at the time such vendor or
24 alternate payee engaged in practices prohibited by
25 applicable federal or State law or regulation
26 relating to the Illinois Medical Assistance

1 Program; or

2 (d) was an owner of a sole proprietorship or
3 partner in a partnership which was a vendor or
4 alternate payee at the time such vendor or
5 alternate payee engaged in practices prohibited by
6 applicable federal or State law or regulation
7 relating to the Illinois Medical Assistance
8 Program; or

9 (7) the direct or indirect ownership of the vendor
10 or alternate payee (including the ownership of a vendor
11 or alternate payee that is a partner's interest in a
12 vendor or alternate payee, or ownership of 5% or more
13 of the shares of stock or other evidences of ownership
14 in a corporate vendor or alternate payee) has been
15 transferred by an individual who is terminated,
16 suspended, or excluded or barred from participating as
17 a vendor or is prohibited or revoked as an alternate
18 payee to the individual's spouse, child, brother,
19 sister, parent, grandparent, grandchild, uncle, aunt,
20 niece, nephew, cousin, or relative by marriage.

21 (K) The Illinois Department of Healthcare and Family
22 Services may withhold payments, in whole or in part, to a
23 provider or alternate payee where there is credible ~~upon~~
24 ~~receipt~~ of evidence, received from State or federal law
25 enforcement or federal oversight agencies or from the results
26 of a preliminary Department audit ~~and determined by the~~

1 ~~Department to be credible~~, that the circumstances giving rise
2 to the need for a withholding of payments may involve fraud or
3 willful misrepresentation under the Illinois Medical
4 Assistance program. The Department shall by rule define what
5 constitutes "credible" evidence for purposes of this
6 subsection. The Department may withhold payments without first
7 notifying the provider or alternate payee of its intention to
8 withhold such payments. A provider or alternate payee may
9 request a reconsideration of payment withholding, and the
10 Department must grant such a request. The Department shall
11 state by rule a process and criteria by which a provider or
12 alternate payee may request full or partial release of payments
13 withheld under this subsection. This request may be made at any
14 time after the Department first withholds such payments.

15 (a) The Illinois Department must send notice of its
16 withholding of program payments within 5 days of taking
17 such action. The notice must set forth the general
18 allegations as to the nature of the withholding action, but
19 need not disclose any specific information concerning its
20 ongoing investigation. The notice must do all of the
21 following:

22 (1) State that payments are being withheld in
23 accordance with this subsection.

24 (2) State that the withholding is for a temporary
25 period, as stated in paragraph (b) of this subsection,
26 and cite the circumstances under which withholding

1 will be terminated.

2 (3) Specify, when appropriate, which type or types
3 of Medicaid claims withholding is effective.

4 (4) Inform the provider or alternate payee of the
5 right to submit written evidence for reconsideration
6 of the withholding by the Illinois Department.

7 (5) Inform the provider or alternate payee that a
8 written request may be made to the Illinois Department
9 for full or partial release of withheld payments and
10 that such requests may be made at any time after the
11 Department first withholds such payments.

12 (b) All withholding-of-payment actions under this
13 subsection shall be temporary and shall not continue after
14 any of the following:

15 (1) The Illinois Department or the prosecuting
16 authorities determine that there is insufficient
17 evidence of fraud or willful misrepresentation by the
18 provider or alternate payee.

19 (2) Legal proceedings related to the provider's or
20 alternate payee's alleged fraud, willful
21 misrepresentation, violations of this Act, or
22 violations of the Illinois Department's administrative
23 rules are completed.

24 (3) The withholding of payments for a period of 3
25 years.

26 (c) The Illinois Department may adopt all rules

1 necessary to implement this subsection (K).

2 (K-5) The Illinois Department may withhold payments, in
3 whole or in part, to a provider or alternate payee upon
4 initiation of an audit, quality of care review, investigation
5 when there is a credible allegation of fraud, or the provider
6 or alternate payee demonstrating a clear failure to cooperate
7 with the Illinois Department such that the circumstances give
8 rise to the need for a withholding of payments. As used in this
9 subsection, "credible allegation" is defined to include an
10 allegation from any source, including, but not limited to,
11 fraud hotline complaints, claims data mining, patterns
12 identified through provider audits, civil actions filed under
13 the False Claims Act, and law enforcement investigations. An
14 allegation is considered to be credible when it has indicia of
15 reliability. The Illinois Department may withhold payments
16 without first notifying the provider or alternate payee of its
17 intention to withhold such payments. A provider or alternate
18 payee may request a hearing or a reconsideration of payment
19 withholding, and the Illinois Department must grant such a
20 request. The Illinois Department shall state by rule a process
21 and criteria by which a provider or alternate payee may request
22 a hearing or a reconsideration for the full or partial release
23 of payments withheld under this subsection. This request may be
24 made at any time after the Illinois Department first withholds
25 such payments.

26 (a) The Illinois Department must send notice of its

1 withholding of program payments within 5 days of taking
2 such action. The notice must set forth the general
3 allegations as to the nature of the withholding action but
4 need not disclose any specific information concerning its
5 ongoing investigation. The notice must do all of the
6 following:

7 (1) State that payments are being withheld in
8 accordance with this subsection.

9 (2) State that the withholding is for a temporary
10 period, as stated in paragraph (b) of this subsection,
11 and cite the circumstances under which withholding
12 will be terminated.

13 (3) Specify, when appropriate, which type or types
14 of claims are withheld.

15 (4) Inform the provider or alternate payee of the
16 right to request a hearing or a reconsideration of the
17 withholding by the Illinois Department, including the
18 ability to submit written evidence.

19 (5) Inform the provider or alternate payee that a
20 written request may be made to the Illinois Department
21 for a hearing or a reconsideration for the full or
22 partial release of withheld payments and that such
23 requests may be made at any time after the Illinois
24 Department first withholds such payments.

25 (b) All withholding of payment actions under this
26 subsection shall be temporary and shall not continue after

1 any of the following:

2 (1) The Illinois Department determines that there
3 is insufficient evidence of fraud, or the provider or
4 alternate payee demonstrates clear cooperation with
5 the Illinois Department, as determined by the Illinois
6 Department, such that the circumstances do not give
7 rise to the need for withholding of payments; or

8 (2) The withholding of payments has lasted for a
9 period in excess of 3 years.

10 (c) The Illinois Department may adopt all rules
11 necessary to implement this subsection (K-5).

12 (L) The Illinois Department shall establish a protocol to
13 enable health care providers to disclose an actual or potential
14 violation of this Section pursuant to a self-referral
15 disclosure protocol, referred to in this subsection as "the
16 protocol". The protocol shall include direction for health care
17 providers on a specific person, official, or office to whom
18 such disclosures shall be made. The Illinois Department shall
19 post information on the protocol on the Illinois Department's
20 public website. The Illinois Department may adopt rules
21 necessary to implement this subsection (L). In addition to
22 other factors that the Illinois Department finds appropriate,
23 the Illinois Department may consider a health care provider's
24 timely use or failure to use the protocol in considering the
25 provider's failure to comply with this Code.

26 (M) Notwithstanding any other provision of this Code, the

1 Illinois Department, at its discretion, may exempt an entity
2 licensed under the Nursing Home Care Act and the ID/DD
3 Community Care Act from the provisions of subsections (A-15),
4 (B), and (C) of this Section if the licensed entity is in
5 receivership.

6 (Source: P.A. 94-265, eff. 1-1-06; 94-975, eff. 6-30-06.)

7 (305 ILCS 5/12-4.38)

8 Sec. 12-4.38. Special FamilyCare provisions. ~~(a)~~ The
9 Department of Healthcare and Family Services may submit to the
10 Comptroller, and the Comptroller is authorized to pay, on
11 behalf of persons enrolled in the FamilyCare Program, claims
12 for services rendered to an enrollee during the period
13 beginning October 1, 2007, and ending on the effective date of
14 any rules adopted to implement the provisions of this
15 amendatory Act of the 96th General Assembly. The authorization
16 for payment of claims applies only to bona fide claims for
17 payment for services rendered. Any claim for payment which is
18 authorized pursuant to the provisions of this amendatory Act of
19 the 96th General Assembly must adhere to all other applicable
20 rules, regulations, and requirements.

21 ~~(b) Each person enrolled in the FamilyCare Program as of~~
22 ~~the effective date of this amendatory Act of the 96th General~~
23 ~~Assembly whose income exceeds 185% of the Federal Poverty~~
24 ~~Level, but is not more than 400% of the Federal Poverty Level,~~
25 ~~may remain enrolled in the FamilyCare Program pursuant to this~~

1 ~~subsection so long as that person continues to meet the~~
2 ~~eligibility criteria established under the emergency rule at 89~~
3 ~~Ill. Adm. Code 120 (Illinois Register Volume 31, page 15854)~~
4 ~~filed November 7, 2007. In no case may a person continue to be~~
5 ~~enrolled in the FamilyCare Program pursuant to this subsection~~
6 ~~if the person's income rises above 400% of the Federal Poverty~~
7 ~~Level or falls below 185% of the Federal Poverty Level at any~~
8 ~~subsequent time. Nothing contained in this subsection shall~~
9 ~~prevent an individual from enrolling in the FamilyCare Program~~
10 ~~as authorized by paragraph 15 of Section 5-2 of this Code if he~~
11 ~~or she otherwise qualifies under that Section.~~

12 ~~(c) In implementing the provisions of this amendatory Act~~
13 ~~of the 96th General Assembly, the Department of Healthcare and~~
14 ~~Family Services is authorized to adopt only those rules~~
15 ~~necessary, including emergency rules. Nothing in this~~
16 ~~amendatory Act of the 96th General Assembly permits the~~
17 ~~Department to adopt rules or issue a decision that expands~~
18 ~~eligibility for the FamilyCare Program to a person whose income~~
19 ~~exceeds 185% of the Federal Poverty Level as determined from~~
20 ~~time to time by the U.S. Department of Health and Human~~
21 ~~Services, unless the Department is provided with express~~
22 ~~statutory authority.~~

23 (Source: P.A. 96-20, eff. 6-30-09.)

24 (305 ILCS 5/12-4.39)

25 Sec. 12-4.39. Dental clinic grant program.

1 (a) Grant program. On and after July 1, 2012, and subject
2 ~~Subject~~ to funding availability, the Department of Healthcare
3 and Family Services may ~~shall~~ administer a grant program. The
4 purpose of this grant program shall be to build the public
5 infrastructure for dental care and to make grants to local
6 health departments, federally qualified health clinics
7 (FQHCs), and rural health clinics (RHCs) for development of
8 comprehensive dental clinics for dental care services. The
9 primary purpose of these new dental clinics will be to increase
10 dental access for low-income and Department of Healthcare and
11 Family Services clients who have no dental arrangements with a
12 dental provider in a project's service area. The dental clinic
13 must be willing to accept out-of-area clients who need dental
14 services, including emergency services for adults and Early and
15 Periodic Screening, Diagnosis and Treatment (EPSDT)-referral
16 children. Medically Underserved Areas (MUAs) and Health
17 Professional Shortage Areas (HPSAs) shall receive special
18 priority for grants under this program.

19 (b) Eligible applicants. The following entities are
20 eligible to apply for grants:

21 (1) Local health departments.

22 (2) Federally Qualified Health Centers (FQHCs).

23 (3) Rural health clinics (RHCs).

24 (c) Use of grant moneys. Grant moneys must be used to
25 support projects that develop dental services to meet the
26 dental health care needs of Department of Healthcare and Family

1 Services Dental Program clients. Grant moneys must be used for
2 operating expenses, including, but not limited to: insurance;
3 dental supplies and equipment; dental support services; and
4 renovation expenses. Grant moneys may not be used to offset
5 existing indebtedness, supplant existing funds, purchase real
6 property, or pay for personnel service salaries for dental
7 employees.

8 (d) Application process. The Department shall establish
9 procedures for applying for dental clinic grants.

10 (Source: P.A. 96-67, eff. 7-23-09; 96-1000, eff. 7-2-10.)

11 (305 ILCS 5/12-10.5)

12 Sec. 12-10.5. Medical Special Purposes Trust Fund.

13 (a) The Medical Special Purposes Trust Fund ("the Fund") is
14 created. Any grant, gift, donation, or legacy of money or
15 securities that the Department of Healthcare and Family
16 Services is authorized to receive under Section 12-4.18 or
17 Section 12-4.19 or any monies from any other source, and that
18 are ~~is~~ dedicated for functions connected with the
19 administration of any medical program administered by the
20 Department, shall be deposited into the Fund. All federal
21 moneys received by the Department as reimbursement for
22 disbursements authorized to be made from the Fund shall also be
23 deposited into the Fund. In addition, federal moneys received
24 on account of State expenditures made in connection with
25 obtaining compliance with the federal Health Insurance

1 Portability and Accountability Act (HIPAA) shall be deposited
2 into the Fund.

3 (b) No moneys received from a service provider or a
4 governmental or private entity that is enrolled with the
5 Department as a provider of medical services shall be deposited
6 into the Fund.

7 (c) Disbursements may be made from the Fund for the
8 purposes connected with the grants, gifts, donations, ~~or~~
9 legacies, or other monies deposited into the Fund, including,
10 but not limited to, medical quality assessment projects,
11 eligibility population studies, medical information systems
12 evaluations, and other administrative functions that assist
13 the Department in fulfilling its health care mission under any
14 medical program administered by the Department.

15 (Source: P.A. 97-48, eff. 6-28-11.)

16 (305 ILCS 5/12-13.1)

17 Sec. 12-13.1. Inspector General.

18 (a) The Governor shall appoint, and the Senate shall
19 confirm, an Inspector General who shall function within the
20 Illinois Department of Public Aid (now Healthcare and Family
21 Services) and report to the Governor. The term of the Inspector
22 General shall expire on the third Monday of January, 1997 and
23 every 4 years thereafter.

24 (b) In order to prevent, detect, and eliminate fraud,
25 waste, abuse, mismanagement, and misconduct, the Inspector

1 General shall oversee the Department of Healthcare and Family
2 Services' integrity functions, which include, but are not
3 limited to, the following:

4 (1) Investigation of misconduct by employees, vendors,
5 contractors and medical providers, except for allegations
6 of violations of the State Officials and Employees Ethics
7 Act which shall be referred to the Office of the Governor's
8 Executive Inspector General for investigation.

9 (2) Prepayment and post-payment audits ~~Audits~~ of
10 medical providers related to ensuring that appropriate
11 payments are made for services rendered and to the
12 prevention and recovery of overpayments.

13 (3) Monitoring of quality assurance programs
14 administered by the Department of Healthcare and Family
15 Services ~~generally related to the medical assistance~~
16 ~~program and specifically related to any managed care~~
17 ~~program.~~

18 (4) Quality control measurements of the programs
19 administered by the Department of Healthcare and Family
20 Services.

21 (5) Investigations of fraud or intentional program
22 violations committed by clients of the Department of
23 Healthcare and Family Services.

24 (6) Actions initiated against contractors, vendors, or
25 medical providers for any of the following reasons:

26 (A) Violations of the medical assistance program.

1 (B) Sanctions against providers brought in
2 conjunction with the Department of Public Health or the
3 Department of Human Services (as successor to the
4 Department of Mental Health and Developmental
5 Disabilities).

6 (C) Recoveries of assessments against hospitals
7 and long-term care facilities.

8 (D) Sanctions mandated by the United States
9 Department of Health and Human Services against
10 medical providers.

11 (E) Violations of contracts related to any
12 programs administered by the Department of Healthcare
13 and Family Services ~~managed care programs~~.

14 (7) Representation of the Department of Healthcare and
15 Family Services at hearings with the Illinois Department of
16 Financial and Professional Regulation in actions taken
17 against professional licenses held by persons who are in
18 violation of orders for child support payments.

19 (b-5) At the request of the Secretary of Human Services,
20 the Inspector General shall, in relation to any function
21 performed by the Department of Human Services as successor to
22 the Department of Public Aid, exercise one or more of the
23 powers provided under this Section as if those powers related
24 to the Department of Human Services; in such matters, the
25 Inspector General shall report his or her findings to the
26 Secretary of Human Services.

1 (c) Notwithstanding, and in addition to, any other
2 provision of law, the ~~The~~ Inspector General shall have access
3 to all information, personnel and facilities of the Department
4 of Healthcare and Family Services and the Department of Human
5 Services (as successor to the Department of Public Aid), their
6 employees, vendors, contractors and medical providers and any
7 federal, State or local governmental agency that are necessary
8 to perform the duties of the Office as directly related to
9 public assistance programs administered by those departments.
10 No medical provider shall be compelled, however, to provide
11 individual medical records of patients who are not clients of
12 the programs administered by the Department of Healthcare and
13 Family Services Medical Assistance Program. State and local
14 governmental agencies are authorized and directed to provide
15 the requested information, assistance or cooperation.

16 For purposes of enhanced program integrity functions and
17 oversight, and to the extent consistent with applicable
18 information and privacy, security, and disclosure laws, State
19 agencies and departments shall provide the Office of Inspector
20 General access to confidential and other information and data,
21 and the Inspector General is authorized to enter into
22 agreements with appropriate federal agencies and departments
23 to secure similar data. This includes, but is not limited to,
24 information pertaining to: licensure; certification; earnings;
25 immigration status; citizenship; wage reporting; unearned and
26 earned income; pension income; employment; supplemental

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

6 The Inspector General shall enter into agreements with
7 State agencies and departments, and is authorized to enter into
8 agreements with federal agencies and departments, under which
9 such agencies and departments shall share data necessary for
10 medical assistance program integrity functions and oversight.

11 The Inspector General shall enter into agreements with State
12 agencies and departments, and is authorized to enter into
13 agreements with federal agencies and departments, under which
14 such agencies shall share data necessary for recipient and
15 vendor screening, review, and investigation, including but not
16 limited to vendor payment and recipient eligibility
17 verification. The Inspector General shall develop, in
18 cooperation with other State and federal agencies and
19 departments, and in compliance with applicable federal laws and
20 regulations, appropriate and effective methods to share such
21 data. The Inspector General shall enter into agreements with
22 State agencies and departments, and is authorized to enter into
23 agreements with federal agencies and departments, including,
24 but not limited to: the Secretary of State; the Department of
25 Revenue; the Department of Public Health; the Department of
26 Human Services; and the Department of Financial and

1 Professional Regulation.

2 The Inspector General shall have the authority to deny
3 payment, prevent overpayments, and recover overpayments.

4 The Inspector General shall have the authority to deny or
5 suspend payment to, and deny, terminate, or suspend the
6 eligibility of, any vendor who fails to grant the Inspector
7 General timely access to full and complete records, including
8 records of recipients under the medical assistance program for
9 the most recent 6 years, in accordance with Section 140.28 of
10 Title 89 of the Illinois Administrative Code, and other
11 information for the purpose of audits, investigations, or other
12 program integrity functions, after reasonable written request
13 by the Inspector General.

14 (d) The Inspector General shall serve as the Department of
15 Healthcare and Family Services' primary liaison with law
16 enforcement, investigatory and prosecutorial agencies,
17 including but not limited to the following:

18 (1) The Department of State Police.

19 (2) The Federal Bureau of Investigation and other
20 federal law enforcement agencies.

21 (3) The various Inspectors General of federal agencies
22 overseeing the programs administered by the Department of
23 Healthcare and Family Services.

24 (4) The various Inspectors General of any other State
25 agencies with responsibilities for portions of programs
26 primarily administered by the Department of Healthcare and

1 Family Services.

2 (5) The Offices of the several United States Attorneys
3 in Illinois.

4 (6) The several State's Attorneys.

5 (7) The offices of the Centers for Medicare and
6 Medicaid Services that administer the Medicare and
7 Medicaid integrity programs.

8 The Inspector General shall meet on a regular basis with
9 these entities to share information regarding possible
10 misconduct by any persons or entities involved with the public
11 aid programs administered by the Department of Healthcare and
12 Family Services.

13 (e) All investigations conducted by the Inspector General
14 shall be conducted in a manner that ensures the preservation of
15 evidence for use in criminal prosecutions. If the Inspector
16 General determines that a possible criminal act relating to
17 fraud in the provision or administration of the medical
18 assistance program has been committed, the Inspector General
19 shall immediately notify the Medicaid Fraud Control Unit. If
20 the Inspector General determines that a possible criminal act
21 has been committed within the jurisdiction of the Office, the
22 Inspector General may request the special expertise of the
23 Department of State Police. The Inspector General may present
24 for prosecution the findings of any criminal investigation to
25 the Office of the Attorney General, the Offices of the several
26 United States Attorneys in Illinois or the several State's

1 Attorneys.

2 (f) To carry out his or her duties as described in this
3 Section, the Inspector General and his or her designees shall
4 have the power to compel by subpoena the attendance and
5 testimony of witnesses and the production of books, electronic
6 records and papers as directly related to public assistance
7 programs administered by the Department of Healthcare and
8 Family Services or the Department of Human Services (as
9 successor to the Department of Public Aid). No medical provider
10 shall be compelled, however, to provide individual medical
11 records of patients who are not clients of the Medical
12 Assistance Program.

13 (g) The Inspector General shall report all convictions,
14 terminations, and suspensions taken against vendors,
15 contractors and medical providers to the Department of
16 Healthcare and Family Services and to any agency responsible
17 for licensing or regulating those persons or entities.

18 (h) The Inspector General shall make annual reports,
19 findings, and recommendations regarding the Office's
20 investigations into reports of fraud, waste, abuse,
21 mismanagement, or misconduct relating to any ~~public aid~~
22 programs administered by the Department of Healthcare and
23 Family Services or the Department of Human Services (as
24 successor to the Department of Public Aid) to the General
25 Assembly and the Governor. These reports shall include, but not
26 be limited to, the following information:

1 (1) Aggregate provider billing and payment
2 information, including the number of providers at various
3 Medicaid earning levels.

4 (2) The number of audits of the medical assistance
5 program and the dollar savings resulting from those audits.

6 (3) The number of prescriptions rejected annually
7 under the Department of Healthcare and Family Services'
8 Refill Too Soon program and the dollar savings resulting
9 from that program.

10 (4) Provider sanctions, in the aggregate, including
11 terminations and suspensions.

12 (5) A detailed summary of the investigations
13 undertaken in the previous fiscal year. These summaries
14 shall comply with all laws and rules regarding maintaining
15 confidentiality in the public aid programs.

16 (i) Nothing in this Section shall limit investigations by
17 the Department of Healthcare and Family Services or the
18 Department of Human Services that may otherwise be required by
19 law or that may be necessary in their capacity as the central
20 administrative authorities responsible for administration of
21 their agency's ~~public aid~~ programs in this State.

22 (j) The Inspector General may issue shields or other
23 distinctive identification to his or her employees not
24 exercising the powers of a peace officer if the Inspector
25 General determines that a shield or distinctive identification
26 is needed by an employee to carry out his or her

1 responsibilities.

2 (Source: P.A. 95-331, eff. 8-21-07; 96-555, eff. 8-18-09;
3 96-1316, eff. 1-1-11.)

4 (305 ILCS 5/14-8) (from Ch. 23, par. 14-8)
5 Sec. 14-8. Disbursements to Hospitals.

6 (a) For inpatient hospital services rendered on and after
7 September 1, 1991, the Illinois Department shall reimburse
8 hospitals for inpatient services at an inpatient payment rate
9 calculated for each hospital based upon the Medicare
10 Prospective Payment System as set forth in Sections 1886(b),
11 (d), (g), and (h) of the federal Social Security Act, and the
12 regulations, policies, and procedures promulgated thereunder,
13 except as modified by this Section. Payment rates for inpatient
14 hospital services rendered on or after September 1, 1991 and on
15 or before September 30, 1992 shall be calculated using the
16 Medicare Prospective Payment rates in effect on September 1,
17 1991. Payment rates for inpatient hospital services rendered on
18 or after October 1, 1992 and on or before March 31, 1994 shall
19 be calculated using the Medicare Prospective Payment rates in
20 effect on September 1, 1992. Payment rates for inpatient
21 hospital services rendered on or after April 1, 1994 shall be
22 calculated using the Medicare Prospective Payment rates
23 (including the Medicare grouping methodology and weighting
24 factors as adjusted pursuant to paragraph (1) of this
25 subsection) in effect 90 days prior to the date of admission.

1 For services rendered on or after July 1, 1995, the
2 reimbursement methodology implemented under this subsection
3 shall not include those costs referred to in Sections
4 1886(d)(5)(B) and 1886(h) of the Social Security Act. The
5 additional payment amounts required under Section
6 1886(d)(5)(F) of the Social Security Act, for hospitals serving
7 a disproportionate share of low-income or indigent patients,
8 are not required under this Section. For hospital inpatient
9 services rendered on or after July 1, 1995, the Illinois
10 Department shall reimburse hospitals using the relative
11 weighting factors and the base payment rates calculated for
12 each hospital that were in effect on June 30, 1995, less the
13 portion of such rates attributed by the Illinois Department to
14 the cost of medical education.

15 (1) The weighting factors established under Section
16 1886(d)(4) of the Social Security Act shall not be used in
17 the reimbursement system established under this Section.
18 Rather, the Illinois Department shall establish by rule
19 Medicaid weighting factors to be used in the reimbursement
20 system established under this Section.

21 (2) The Illinois Department shall define by rule those
22 hospitals or distinct parts of hospitals that shall be
23 exempt from the reimbursement system established under
24 this Section. In defining such hospitals, the Illinois
25 Department shall take into consideration those hospitals
26 exempt from the Medicare Prospective Payment System as of

1 September 1, 1991. For hospitals defined as exempt under
2 this subsection, the Illinois Department shall by rule
3 establish a reimbursement system for payment of inpatient
4 hospital services rendered on and after September 1, 1991.
5 For all hospitals that are children's hospitals as defined
6 in Section 5-5.02 of this Code, the reimbursement
7 methodology shall, through June 30, 1992, net of all
8 applicable fees, at least equal each children's hospital
9 1990 ICARE payment rates, indexed to the current year by
10 application of the DRI hospital cost index from 1989 to the
11 year in which payments are made. Excepting county providers
12 as defined in Article XV of this Code, hospitals licensed
13 under the University of Illinois Hospital Act, and
14 facilities operated by the Department of Mental Health and
15 Developmental Disabilities (or its successor, the
16 Department of Human Services) for hospital inpatient
17 services rendered on or after July 1, 1995, the Illinois
18 Department shall reimburse children's hospitals, as
19 defined in 89 Illinois Administrative Code Section
20 149.50(c)(3), at the rates in effect on June 30, 1995, and
21 shall reimburse all other hospitals at the rates in effect
22 on June 30, 1995, less the portion of such rates attributed
23 by the Illinois Department to the cost of medical
24 education. For inpatient hospital services provided on or
25 after August 1, 1998, the Illinois Department may establish
26 by rule a means of adjusting the rates of children's

1 hospitals, as defined in 89 Illinois Administrative Code
2 Section 149.50(c)(3), that did not meet that definition on
3 June 30, 1995, in order for the inpatient hospital rates of
4 such hospitals to take into account the average inpatient
5 hospital rates of those children's hospitals that did meet
6 the definition of children's hospitals on June 30, 1995.

7 (3) (Blank)

8 (4) Notwithstanding any other provision of this
9 Section, hospitals that on August 31, 1991, have a contract
10 with the Illinois Department under Section 3-4 of the
11 Illinois Health Finance Reform Act may elect to continue to
12 be reimbursed at rates stated in such contracts for general
13 and specialty care.

14 (5) In addition to any payments made under this
15 subsection (a), the Illinois Department shall make the
16 adjustment payments required by Section 5-5.02 of this
17 Code; provided, that in the case of any hospital reimbursed
18 under a per case methodology, the Illinois Department shall
19 add an amount equal to the product of the hospital's
20 average length of stay, less one day, multiplied by 20, for
21 inpatient hospital services rendered on or after September
22 1, 1991 and on or before September 30, 1992.

23 (b) (Blank)

24 (b-5) Excepting county providers as defined in Article XV
25 of this Code, hospitals licensed under the University of
26 Illinois Hospital Act, and facilities operated by the Illinois

1 Department of Mental Health and Developmental Disabilities (or
2 its successor, the Department of Human Services), for
3 outpatient services rendered on or after July 1, 1995 and
4 before July 1, 1998 the Illinois Department shall reimburse
5 children's hospitals, as defined in the Illinois
6 Administrative Code Section 149.50(c)(3), at the rates in
7 effect on June 30, 1995, less that portion of such rates
8 attributed by the Illinois Department to the outpatient
9 indigent volume adjustment and shall reimburse all other
10 hospitals at the rates in effect on June 30, 1995, less the
11 portions of such rates attributed by the Illinois Department to
12 the cost of medical education and attributed by the Illinois
13 Department to the outpatient indigent volume adjustment. For
14 outpatient services provided on or after July 1, 1998,
15 reimbursement rates shall be established by rule.

16 (c) In addition to any other payments under this Code, the
17 Illinois Department shall develop a hospital disproportionate
18 share reimbursement methodology that, effective July 1, 1991,
19 through September 30, 1992, shall reimburse hospitals
20 sufficiently to expend the fee monies described in subsection
21 (b) of Section 14-3 of this Code and the federal matching funds
22 received by the Illinois Department as a result of expenditures
23 made by the Illinois Department as required by this subsection
24 (c) and Section 14-2 that are attributable to fee monies
25 deposited in the Fund, less amounts applied to adjustment
26 payments under Section 5-5.02.

1 (d) Critical Care Access Payments.

2 (1) In addition to any other payments made under this
3 Code, the Illinois Department shall develop a
4 reimbursement methodology that shall reimburse Critical
5 Care Access Hospitals for the specialized services that
6 qualify them as Critical Care Access Hospitals. No
7 adjustment payments shall be made under this subsection on
8 or after July 1, 1995.

9 (2) "Critical Care Access Hospitals" includes, but is
10 not limited to, hospitals that meet at least one of the
11 following criteria:

12 (A) Hospitals located outside of a metropolitan
13 statistical area that are designated as Level II
14 Perinatal Centers and that provide a disproportionate
15 share of perinatal services to recipients; or

16 (B) Hospitals that are designated as Level I Trauma
17 Centers (adult or pediatric) and certain Level II
18 Trauma Centers as determined by the Illinois
19 Department; or

20 (C) Hospitals located outside of a metropolitan
21 statistical area and that provide a disproportionate
22 share of obstetrical services to recipients.

23 (e) Inpatient high volume adjustment. For hospital
24 inpatient services, effective with rate periods beginning on or
25 after October 1, 1993, in addition to rates paid for inpatient
26 services by the Illinois Department, the Illinois Department

1 shall make adjustment payments for inpatient services
2 furnished by Medicaid high volume hospitals. The Illinois
3 Department shall establish by rule criteria for qualifying as a
4 Medicaid high volume hospital and shall establish by rule a
5 reimbursement methodology for calculating these adjustment
6 payments to Medicaid high volume hospitals. No adjustment
7 payment shall be made under this subsection for services
8 rendered on or after July 1, 1995.

9 (f) The Illinois Department shall modify its current rules
10 governing adjustment payments for targeted access, critical
11 care access, and uncompensated care to classify those
12 adjustment payments as not being payments to disproportionate
13 share hospitals under Title XIX of the federal Social Security
14 Act. Rules adopted under this subsection shall not be effective
15 with respect to services rendered on or after July 1, 1995. The
16 Illinois Department has no obligation to adopt or implement any
17 rules or make any payments under this subsection for services
18 rendered on or after July 1, 1995.

19 (f-5) The State recognizes that adjustment payments to
20 hospitals providing certain services or incurring certain
21 costs may be necessary to assure that recipients of medical
22 assistance have adequate access to necessary medical services.
23 These adjustments include payments for teaching costs and
24 uncompensated care, trauma center payments, rehabilitation
25 hospital payments, perinatal center payments, obstetrical care
26 payments, targeted access payments, Medicaid high volume

1 payments, and outpatient indigent volume payments. On or before
2 April 1, 1995, the Illinois Department shall issue
3 recommendations regarding (i) reimbursement mechanisms or
4 adjustment payments to reflect these costs and services,
5 including methods by which the payments may be calculated and
6 the method by which the payments may be financed, and (ii)
7 reimbursement mechanisms or adjustment payments to reflect
8 costs and services of federally qualified health centers with
9 respect to recipients of medical assistance.

10 (g) If one or more hospitals file suit in any court
11 challenging any part of this Article XIV, payments to hospitals
12 under this Article XIV shall be made only to the extent that
13 sufficient monies are available in the Fund and only to the
14 extent that any monies in the Fund are not prohibited from
15 disbursement under any order of the court.

16 (h) Payments under the disbursement methodology described
17 in this Section are subject to approval by the federal
18 government in an appropriate State plan amendment.

19 (i) The Illinois Department may by rule establish criteria
20 for and develop methodologies for adjustment payments to
21 hospitals participating under this Article.

22 (j) Hospital Residing Long Term Care Services. In addition
23 to any other payments made under this Code, the Illinois
24 Department may by rule establish criteria and develop
25 methodologies for payments to hospitals for Hospital Residing
26 Long Term Care Services.

1 (k) Critical Access Hospital outpatient payments. In
2 addition to any other payments authorized under this Code, the
3 Illinois Department shall reimburse critical access hospitals,
4 as designated by the Illinois Department of Public Health in
5 accordance with 42 CFR 485, Subpart F, for outpatient services
6 at an amount that is no less than the cost of providing such
7 services, based on Medicare cost principles. Payments under
8 this subsection shall be subject to appropriation.

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

14 (Source: P.A. 96-1382, eff. 1-1-11.)

15 (305 ILCS 5/14-11 new)

16 Sec. 14-11. Hospital payment reform.

17 (a) The Department may, by rule, implement the All Patient
18 Refined Diagnosis Related Groups (APR-DRG) payment system for
19 inpatient services provided on or after July 1, 2013, in a
20 manner consistent with the actions authorized in this Section.

21 (b) On or before October 1, 2012 and through June 30, 2013,
22 the Department shall begin testing the APR-DRG system. During
23 the testing period the Department shall process and price
24 inpatient services using the APR-DRG system; however, actual
25 payments for those inpatient services shall be made using the

1 current reimbursement system. During the testing period, the
2 Department, in collaboration with the statewide representative
3 of hospitals, shall provide information and technical
4 assistance to hospitals to encourage and facilitate their
5 transition to the APR-DRG system.

6 (c) The Department may, by rule, implement the Enhanced
7 Ambulatory Procedure Grouping (EAPG) system for outpatient
8 services provided on or after January 1, 2014, in a manner
9 consistent with the actions authorized in this Section. On or
10 before January 1, 2013 and through December 31, 2013, the
11 Department shall begin testing the EAPG system. During the
12 testing period the Department shall process and price
13 outpatient services using the EAPG system; however, actual
14 payments for those outpatient services shall be made using the
15 current reimbursement system. During the testing period, the
16 Department, in collaboration with the statewide representative
17 of hospitals, shall provide information and technical
18 assistance to hospitals to encourage and facilitate their
19 transition to the EAPG system.

20 (d) The Department in consultation with the current
21 hospital technical advisory group shall review the test claims
22 for inpatient and outpatient services at least monthly,
23 including the estimated impact on hospitals, and, in developing
24 the rules, policies, and procedures to implement the new
25 payment systems, shall consider at least the following issues:

26 (1) The use of national relative weights provided by

1 the vendor of the APR-DRG system, adjusted to reflect
2 characteristics of the Illinois Medical Assistance
3 population.

4 (2) An updated outlier payment methodology based on
5 current data and consistent with the APR-DRG system.

6 (3) The use of policy adjusters to enhance payments to
7 hospitals treating a high percentage of individuals
8 covered by the Medical Assistance program and uninsured
9 patients.

10 (4) Reimbursement for inpatient specialty services
11 such as psychiatric, rehabilitation, and long-term acute
12 care using updated per diem rates that account for service
13 acuity.

14 (5) The creation of one or more transition funding
15 pools to preserve access to care and to ensure financial
16 stability as hospitals transition to the new payment
17 system.

18 (6) Whether, beginning July 1, 2014, some of the static
19 adjustment payments financed by General Revenue funds
20 should be used as part of the base payment system,
21 including as policy adjusters to recognize the additional
22 costs of certain services, such as pediatric or neonatal,
23 or providers, such as trauma centers, Critical Access
24 Hospitals, or high Medicaid hospitals, or for services to
25 uninsured patients.

26 (e) The Department shall provide the association

1 representing the majority of hospitals in Illinois, as the
2 statewide representative of the hospital community, with a
3 monthly file of claims adjudicated under the test system for
4 the purpose of review and analysis as part of the collaboration
5 between the State and the hospital community. The file shall
6 consist of a de-identified extract compliant with the Health
7 Insurance Portability and Accountability Act (HIPAA).

8 (f) The current hospital technical advisory group shall
9 make recommendations for changes during the testing period and
10 recommendations for changes prior to the effective dates of the
11 new payment systems. The Department shall draft administrative
12 rules to implement the new payment systems and provide them to
13 the technical advisory group at least 90 days prior to the
14 proposed effective dates of the new payment systems.

15 (g) The payments to hospitals financed by the current
16 hospital assessment, authorized under Article V-A of this Code,
17 are scheduled to sunset on June 30, 2014. The continuation of
18 or revisions to the hospital assessment program shall take into
19 consideration the impact on hospitals and access to care as a
20 result of the changes to the hospital payment system.

21 (h) Beginning July 1, 2014, the Department may transition
22 current General Revenue funded supplemental payments into the
23 claims based system over a period of no less than 2 years from
24 the implementation date of the new payment systems and no more
25 than 4 years from the implementation date of the new payment
26 systems, provided however that the Department may adopt, by

1 rule, supplemental payments to help ensure access to care in a
2 geographic area or to help ensure access to specialty services.
3 For any supplemental payments that are adopted that are based
4 on historic data, the data shall be no older than 3 years and
5 the supplemental payment shall be effective for no longer than
6 2 years before requiring the data to be updated.

7 (i) Any payments authorized under 89 Illinois
8 Administrative Code 148 set to expire in State fiscal year 2012
9 and that were paid out to hospitals in State fiscal year 2012,
10 shall remain in effect as long as the assessment imposed by
11 Section 5A-2 is in effect.

12 (j) Subsections (a) and (c) of this Section shall remain
13 operative unless the Auditor General has certified that: (i)
14 the Department has not undertaken the required actions listed
15 in the report required by subsection (a) of Section 2-20 of the
16 Illinois State Auditing Act; or (ii) the Department has failed
17 to comply with the reporting requirements of Section 2-20 of
18 the Illinois State Auditing Act.

19 (k) Subsections (a) and (c) of this Section shall not be
20 operative until final federal approval by the Centers for
21 Medicare and Medicaid Services of the U.S. Department of Health
22 and Human Services and implementation of all of the payments
23 and assessments in Article V-A in its form as of the effective
24 date of this amendatory Act of the 97th General Assembly or as
25 it may be amended.

1 (305 ILCS 5/15-1) (from Ch. 23, par. 15-1)

2 Sec. 15-1. Definitions. As used in this Article, unless the
3 context requires otherwise:

4 (a) (Blank). ~~"Base amount" means \$108,800,000 multiplied~~
5 ~~by a fraction, the numerator of which is the number of days~~
6 ~~represented by the payments in question and the denominator of~~
7 ~~which is 365.~~

8 (a-5) "County provider" means a health care provider that
9 is, or is operated by, a county with a population greater than
10 3,000,000.

11 (b) "Fund" means the County Provider Trust Fund.

12 (c) "Hospital" or "County hospital" means a hospital, as
13 defined in Section 14-1 of this Code, which is a county
14 hospital located in a county of over 3,000,000 population.

15 (Source: P.A. 87-13; 88-85; 88-554, eff. 7-26-94.)

16 (305 ILCS 5/15-2) (from Ch. 23, par. 15-2)

17 Sec. 15-2. County Provider Trust Fund.

18 (a) There is created in the State Treasury the County
19 Provider Trust Fund. Interest earned by the Fund shall be
20 credited to the Fund. The Fund shall not be used to replace any
21 funds appropriated to the Medicaid program by the General
22 Assembly.

23 (b) The Fund is created solely for the purposes of
24 receiving, investing, and distributing monies in accordance
25 with this Article XV. The Fund shall consist of:

1 (1) All monies collected or received by the Illinois
2 Department under Section 15-3 of this Code;

3 (2) All federal financial participation monies
4 received by the Illinois Department pursuant to Title XIX
5 of the Social Security Act, 42 U.S.C. 1396b, attributable
6 to eligible expenditures made by the Illinois Department
7 pursuant to Section 15-5 of this Code;

8 (3) All federal moneys received by the Illinois
9 Department pursuant to Title XXI of the Social Security Act
10 attributable to eligible expenditures made by the Illinois
11 Department pursuant to Section 15-5 of this Code; and

12 (4) All other monies received by the Fund from any
13 source, including interest thereon.

14 (c) Disbursements from the Fund shall be by warrants drawn
15 by the State Comptroller upon receipt of vouchers duly executed
16 and certified by the Illinois Department and shall be made
17 only:

18 (1) For hospital inpatient care, hospital outpatient
19 care, care provided by other outpatient facilities
20 operated by a county, and disproportionate share hospital
21 adjustment payments made under Title XIX of the Social
22 Security Act and Article V of this Code as required by
23 Section 15-5 of this Code;

24 (1.5) For services provided or purchased by county
25 providers pursuant to Section 5-11 of this Code;

26 (2) For the reimbursement of administrative expenses

1 incurred by county providers on behalf of the Illinois
2 Department as permitted by Section 15-4 of this Code;

3 (3) For the reimbursement of monies received by the
4 Fund through error or mistake;

5 (4) For the payment of administrative expenses
6 necessarily incurred by the Illinois Department or its
7 agent in performing the activities required by this Article
8 XV;

9 (5) For the payment of any amounts that are
10 reimbursable to the federal government, attributable
11 solely to the Fund, and required to be paid by State
12 warrant; and

13 (6) For hospital inpatient care, hospital outpatient
14 care, care provided by other outpatient facilities
15 operated by a county, and disproportionate share hospital
16 adjustment payments made under Title XXI of the Social
17 Security Act, pursuant to Section 15-5 of this Code.

18 (7) For medical care and related services provided
19 pursuant to a contract with a county.

20 (Source: P.A. 95-859, eff. 8-19-08.)

21 (305 ILCS 5/15-5) (from Ch. 23, par. 15-5)

22 Sec. 15-5. Disbursements from the Fund.

23 (a) The monies in the Fund shall be disbursed only as
24 provided in Section 15-2 of this Code and as follows:

25 (1) To the extent that such costs are reimbursable

1 under federal law, to pay the county hospitals' inpatient
2 reimbursement rates based on actual costs incurred,
3 trended forward annually by an inflation index.

4 (2) To the extent that such costs are reimbursable
5 under federal law, to pay county hospitals and county
6 operated outpatient facilities for outpatient services
7 based on a federally approved methodology to cover the
8 maximum allowable costs.

9 (3) To pay the county hospitals disproportionate share
10 hospital adjustment payments as may be specified in the
11 Illinois Title XIX State plan.

12 (3.5) To pay county providers for services provided or
13 purchased pursuant to Section 5-11 of this Code.

14 (4) To reimburse the county providers for expenses
15 contractually assumed pursuant to Section 15-4 of this
16 Code.

17 (5) To pay the Illinois Department its necessary
18 administrative expenses relative to the Fund and other
19 amounts agreed to, if any, by the county providers in the
20 agreement provided for in subsection (c).

21 (6) To pay the county providers any other amount due
22 according to a federally approved State plan, including but
23 not limited to payments made under the provisions of
24 Section 701(d)(3)(B) of the federal Medicare, Medicaid,
25 and SCHIP Benefits Improvement and Protection Act of 2000.
26 Intergovernmental transfers supporting payments under this

1 paragraph (6) shall not be subject to the computation
2 described in subsection (a) of Section 15-3 of this Code,
3 but shall be computed as the difference between the total
4 of such payments made by the Illinois Department to county
5 providers less any amount of federal financial
6 participation due the Illinois Department under Titles XIX
7 and XXI of the Social Security Act as a result of such
8 payments to county providers.

9 (b) The Illinois Department shall promptly seek all
10 appropriate amendments to the Illinois Title XIX State Plan to
11 maximize reimbursement, including disproportionate share
12 hospital adjustment payments, to the county providers.

13 (c) (Blank).

14 (d) The payments provided for herein are intended to cover
15 services rendered on and after July 1, 1991, and any agreement
16 executed between a qualifying county and the Illinois
17 Department pursuant to this Section may relate back to that
18 date, provided the Illinois Department obtains federal
19 approval. Any changes in payment rates resulting from the
20 provisions of Article 3 of this amendatory Act of 1992 are
21 intended to apply to services rendered on or after October 1,
22 1992, and any agreement executed between a qualifying county
23 and the Illinois Department pursuant to this Section may be
24 effective as of that date.

25 (e) If one or more hospitals file suit in any court
26 challenging any part of this Article XV, payments to hospitals

1 from the Fund under this Article XV shall be made only to the
2 extent that sufficient monies are available in the Fund and
3 only to the extent that any monies in the Fund are not
4 prohibited from disbursement and may be disbursed under any
5 order of the court.

6 (f) All payments under this Section are contingent upon
7 federal approval of changes to the Title XIX State plan, if
8 that approval is required.

9 (Source: P.A. 95-859, eff. 8-19-08.)

10 (305 ILCS 5/15-11)

11 Sec. 15-11. Uses of State funds.

12 (a) At any point, if State revenues referenced in
13 subsection (b) or (c) of Section 15-10 or additional State
14 grants are disbursed to the Cook County Health and Hospitals
15 System, all funds may be used only for the following:

16 (1) medical services provided at hospitals or clinics
17 owned and operated by the Cook County Health and Hospitals
18 System Bureau of Health Services; ~~or~~

19 (2) information technology to enhance billing
20 capabilities for medical claiming and reimbursement; or ~~or~~

21 (3) services purchased by county providers pursuant to
22 Section 5-11 of this Code.

23 (b) State funds may not be used for the following:

24 (1) non-clinical services, except services that may be
25 required by accreditation bodies or State or federal

1 regulatory or licensing authorities;

2 (2) non-clinical support staff, except as pursuant to
3 paragraph (1) of this subsection; or

4 (3) capital improvements, other than investments in
5 medical technology, except for capital improvements that
6 may be required by accreditation bodies or State or federal
7 regulatory or licensing authorities.

8 (Source: P.A. 95-859, eff. 8-19-08.)

9 Section 85. The Pediatric Palliative Care Act is amended by
10 adding Section 3 as follows:

11 (305 ILCS 60/3 new)

12 Sec. 3. Act inoperative. Notwithstanding any other
13 provision of law, this Act is inoperative on and after July 1,
14 2012.

15 (305 ILCS 5/5-5.4a rep.)

16 (305 ILCS 5/5-5.4c rep.)

17 (305 ILCS 5/12-4.36 rep.)

18 Section 88. The Illinois Public Aid Code is amended by
19 repealing Sections 5-5.4a, 5-5.4c, and 12-4.36.

20 Section 90. The Senior Citizens and Disabled Persons
21 Property Tax Relief and Pharmaceutical Assistance Act is
22 amended by changing the title of the Act and Sections 1, 1.5,

1 2, 3.05a, 3.10, 4, 4.05, 5, 6, 7, 8, 9, 12, and 13 as follows:

2 (320 ILCS 25/Act title)

3 An Act in relation to the payment of grants to enable the
4 elderly and the disabled to acquire or retain private housing
5 ~~and to acquire prescription drugs.~~

6 (320 ILCS 25/1) (from Ch. 67 1/2, par. 401)

7 Sec. 1. Short title; common name. This Article shall be
8 known and may be cited as the Senior Citizens and Disabled
9 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.
10 Common references to the "Circuit Breaker Act" mean this
11 Article. As used in this Article, "this Act" means this
12 Article.

13 (Source: P.A. 96-804, eff. 1-1-10.)

14 (320 ILCS 25/1.5)

15 Sec. 1.5. Implementation of Executive Order No. 3 of 2004;
16 termination of the Illinois Senior Citizens and Disabled
17 Persons Pharmaceutical Assistance Program. Executive Order No.
18 3 of 2004, in part, provided for the transfer of the programs
19 under this Act from the Department of Revenue to the Department
20 on Aging and the Department of Healthcare and Family Services.
21 It is the purpose of this amendatory Act of the 96th General
22 Assembly to conform this Act and certain related provisions of
23 other statutes to that Executive Order. This amendatory Act of

1 the 96th General Assembly also makes other substantive changes
2 to this Act.

3 It is the purpose of this amendatory Act of the 97th
4 General Assembly to terminate the Illinois Senior Citizens and
5 Disabled Persons Pharmaceutical Assistance Program on July 1,
6 2012.

7 (Source: P.A. 96-804, eff. 1-1-10.)

8 (320 ILCS 25/2) (from Ch. 67 1/2, par. 402)

9 Sec. 2. Purpose. The purpose of this Act is to provide
10 incentives to the senior citizens and disabled persons of this
11 State to acquire and retain private housing of their choice and
12 at the same time to relieve those citizens from the burdens of
13 extraordinary property taxes ~~and rising drug costs~~ against
14 their increasingly restricted earning power, and thereby to
15 reduce the requirements for public housing in this State.

16 (Source: P.A. 96-804, eff. 1-1-10.)

17 (320 ILCS 25/3.05a)

18 Sec. 3.05a. Additional resident. "Additional resident"
19 means a person who (i) is living in the same residence with a
20 claimant for the claim year and at the time of filing the
21 claim, (ii) is not the spouse of the claimant, (iii) does not
22 file a separate claim under this Act for the same period, and
23 (iv) receives more than half of his or her total financial
24 support for that claim year from the household. Prior to July

1 1, 2012, an ~~An~~ additional resident who meets qualifications may
2 receive pharmaceutical assistance based on a claimant's
3 application.

4 (Source: P.A. 96-804, eff. 1-1-10.)

5 (320 ILCS 25/3.10) (from Ch. 67 1/2, par. 403.10)

6 Sec. 3.10. Regulations. "Regulations" includes both rules
7 promulgated and forms prescribed by the applicable Department.
8 In this Act, references to the rules of the Department on Aging
9 or the Department of Healthcare and Family Services, in effect
10 prior to July 1, 2012, shall be deemed to include, in
11 appropriate cases, the corresponding rules adopted by the
12 Department of Revenue, to the extent that those rules continue
13 in force under Executive Order No. 3 of 2004.

14 (Source: P.A. 96-804, eff. 1-1-10.)

15 (320 ILCS 25/4) (from Ch. 67 1/2, par. 404)

16 Sec. 4. Amount of Grant.

17 (a) In general. Any individual 65 years or older or any
18 individual who will become 65 years old during the calendar
19 year in which a claim is filed, and any surviving spouse of
20 such a claimant, who at the time of death received or was
21 entitled to receive a grant pursuant to this Section, which
22 surviving spouse will become 65 years of age within the 24
23 months immediately following the death of such claimant and
24 which surviving spouse but for his or her age is otherwise

1 qualified to receive a grant pursuant to this Section, and any
2 disabled person whose annual household income is less than the
3 income eligibility limitation, as defined in subsection (a-5)
4 and whose household is liable for payment of property taxes
5 accrued or has paid rent constituting property taxes accrued
6 and is domiciled in this State at the time he or she files his
7 or her claim is entitled to claim a grant under this Act. With
8 respect to claims filed by individuals who will become 65 years
9 old during the calendar year in which a claim is filed, the
10 amount of any grant to which that household is entitled shall
11 be an amount equal to 1/12 of the amount to which the claimant
12 would otherwise be entitled as provided in this Section,
13 multiplied by the number of months in which the claimant was 65
14 in the calendar year in which the claim is filed.

15 (a-5) Income eligibility limitation. For purposes of this
16 Section, "income eligibility limitation" means an amount for
17 grant years 2008 and thereafter:

18 (1) less than \$22,218 for a household containing one
19 person;

20 (2) less than \$29,480 for a household containing 2
21 persons; or

22 (3) less than \$36,740 for a household containing 3 or
23 more persons.

24 For 2009 claim year applications submitted during calendar
25 year 2010, a household must have annual household income of
26 less than \$27,610 for a household containing one person; less

1 than \$36,635 for a household containing 2 persons; or less than
2 \$45,657 for a household containing 3 or more persons.

3 The Department on Aging may adopt rules such that on
4 January 1, 2011, and thereafter, the foregoing household income
5 eligibility limits may be changed to reflect the annual cost of
6 living adjustment in Social Security and Supplemental Security
7 Income benefits that are applicable to the year for which those
8 benefits are being reported as income on an application.

9 If a person files as a surviving spouse, then only his or
10 her income shall be counted in determining his or her household
11 income.

12 (b) Limitation. Except as otherwise provided in
13 subsections (a) and (f) of this Section, the maximum amount of
14 grant which a claimant is entitled to claim is the amount by
15 which the property taxes accrued which were paid or payable
16 during the last preceding tax year or rent constituting
17 property taxes accrued upon the claimant's residence for the
18 last preceding taxable year exceeds 3 1/2% of the claimant's
19 household income for that year but in no event is the grant to
20 exceed (i) \$700 less 4.5% of household income for that year for
21 those with a household income of \$14,000 or less or (ii) \$70 if
22 household income for that year is more than \$14,000.

23 (c) Public aid recipients. If household income in one or
24 more months during a year includes cash assistance in excess of
25 \$55 per month from the Department of Healthcare and Family
26 Services or the Department of Human Services (acting as

1 successor to the Department of Public Aid under the Department
2 of Human Services Act) which was determined under regulations
3 of that Department on a measure of need that included an
4 allowance for actual rent or property taxes paid by the
5 recipient of that assistance, the amount of grant to which that
6 household is entitled, except as otherwise provided in
7 subsection (a), shall be the product of (1) the maximum amount
8 computed as specified in subsection (b) of this Section and (2)
9 the ratio of the number of months in which household income did
10 not include such cash assistance over \$55 to the number twelve.
11 If household income did not include such cash assistance over
12 \$55 for any months during the year, the amount of the grant to
13 which the household is entitled shall be the maximum amount
14 computed as specified in subsection (b) of this Section. For
15 purposes of this paragraph (c), "cash assistance" does not
16 include any amount received under the federal Supplemental
17 Security Income (SSI) program.

18 (d) Joint ownership. If title to the residence is held
19 jointly by the claimant with a person who is not a member of
20 his or her household, the amount of property taxes accrued used
21 in computing the amount of grant to which he or she is entitled
22 shall be the same percentage of property taxes accrued as is
23 the percentage of ownership held by the claimant in the
24 residence.

25 (e) More than one residence. If a claimant has occupied
26 more than one residence in the taxable year, he or she may

1 claim only one residence for any part of a month. In the case
2 of property taxes accrued, he or she shall prorate 1/12 of the
3 total property taxes accrued on his or her residence to each
4 month that he or she owned and occupied that residence; and, in
5 the case of rent constituting property taxes accrued, shall
6 prorate each month's rent payments to the residence actually
7 occupied during that month.

8 (f) (Blank).

9 (g) Effective January 1, 2006, there is hereby established
10 a program of pharmaceutical assistance to the aged and
11 disabled, entitled the Illinois Seniors and Disabled Drug
12 Coverage Program, which shall be administered by the Department
13 of Healthcare and Family Services and the Department on Aging
14 in accordance with this subsection, to consist of coverage of
15 specified prescription drugs on behalf of beneficiaries of the
16 program as set forth in this subsection. Notwithstanding any
17 provisions of this Act to the contrary, on and after July 1,
18 2012, pharmaceutical assistance under this Act shall no longer
19 be provided, and on July 1, 2012 the Illinois Senior Citizens
20 and Disabled Persons Pharmaceutical Assistance Program shall
21 terminate. The following provisions that concern the Illinois
22 Senior Citizens and Disabled Persons Pharmaceutical Assistance
23 Program shall continue to apply on and after July 1, 2012 to
24 the extent necessary to pursue any actions authorized by
25 subsection (d) of Section 9 of this Act with respect to acts
26 which took place prior to July 1, 2012.

1 To become a beneficiary under the program established under
2 this subsection, a person must:

3 (1) be (i) 65 years of age or older or (ii) disabled;
4 and

5 (2) be domiciled in this State; and

6 (3) enroll with a qualified Medicare Part D
7 Prescription Drug Plan if eligible and apply for all
8 available subsidies under Medicare Part D; and

9 (4) for the 2006 and 2007 claim years, have a maximum
10 household income of (i) less than \$21,218 for a household
11 containing one person, (ii) less than \$28,480 for a
12 household containing 2 persons, or (iii) less than \$35,740
13 for a household containing 3 or more persons; and

14 (5) for the 2008 claim year, have a maximum household
15 income of (i) less than \$22,218 for a household containing
16 one person, (ii) \$29,480 for a household containing 2
17 persons, or (iii) \$36,740 for a household containing 3 or
18 more persons; and

19 (6) for 2009 claim year applications submitted during
20 calendar year 2010, have annual household income of less
21 than (i) \$27,610 for a household containing one person;
22 (ii) less than \$36,635 for a household containing 2
23 persons; or (iii) less than \$45,657 for a household
24 containing 3 or more persons; and

25 (7) as of September 1, 2011, have a maximum household
26 income at or below 200% of the federal poverty level.

1 All individuals enrolled as of December 31, 2005, in the
2 pharmaceutical assistance program operated pursuant to
3 subsection (f) of this Section and all individuals enrolled as
4 of December 31, 2005, in the SeniorCare Medicaid waiver program
5 operated pursuant to Section 5-5.12a of the Illinois Public Aid
6 Code shall be automatically enrolled in the program established
7 by this subsection for the first year of operation without the
8 need for further application, except that they must apply for
9 Medicare Part D and the Low Income Subsidy under Medicare Part
10 D. A person enrolled in the pharmaceutical assistance program
11 operated pursuant to subsection (f) of this Section as of
12 December 31, 2005, shall not lose eligibility in future years
13 due only to the fact that they have not reached the age of 65.

14 To the extent permitted by federal law, the Department may
15 act as an authorized representative of a beneficiary in order
16 to enroll the beneficiary in a Medicare Part D Prescription
17 Drug Plan if the beneficiary has failed to choose a plan and,
18 where possible, to enroll beneficiaries in the low-income
19 subsidy program under Medicare Part D or assist them in
20 enrolling in that program.

21 Beneficiaries under the program established under this
22 subsection shall be divided into the following 4 eligibility
23 groups:

24 (A) Eligibility Group 1 shall consist of beneficiaries
25 who are not eligible for Medicare Part D coverage and who
26 are:

1 (i) disabled and under age 65; or

2 (ii) age 65 or older, with incomes over 200% of the
3 Federal Poverty Level; or

4 (iii) age 65 or older, with incomes at or below
5 200% of the Federal Poverty Level and not eligible for
6 federally funded means-tested benefits due to
7 immigration status.

8 (B) Eligibility Group 2 shall consist of beneficiaries
9 who are eligible for Medicare Part D coverage.

10 (C) Eligibility Group 3 shall consist of beneficiaries
11 age 65 or older, with incomes at or below 200% of the
12 Federal Poverty Level, who are not barred from receiving
13 federally funded means-tested benefits due to immigration
14 status and are not eligible for Medicare Part D coverage.

15 If the State applies and receives federal approval for
16 a waiver under Title XIX of the Social Security Act,
17 persons in Eligibility Group 3 shall continue to receive
18 benefits through the approved waiver, and Eligibility
19 Group 3 may be expanded to include disabled persons under
20 age 65 with incomes under 200% of the Federal Poverty Level
21 who are not eligible for Medicare and who are not barred
22 from receiving federally funded means-tested benefits due
23 to immigration status.

24 (D) Eligibility Group 4 shall consist of beneficiaries
25 who are otherwise described in Eligibility Group 2 who have
26 a diagnosis of HIV or AIDS.

1 The program established under this subsection shall cover
2 the cost of covered prescription drugs in excess of the
3 beneficiary cost-sharing amounts set forth in this paragraph
4 that are not covered by Medicare. The Department of Healthcare
5 and Family Services may establish by emergency rule changes in
6 cost-sharing necessary to conform the cost of the program to
7 the amounts appropriated for State fiscal year 2012 and future
8 fiscal years except that the 24-month limitation on the
9 adoption of emergency rules and the provisions of Sections
10 5-115 and 5-125 of the Illinois Administrative Procedure Act
11 shall not apply to rules adopted under this subsection (g). The
12 adoption of emergency rules authorized by this subsection (g)
13 shall be deemed to be necessary for the public interest,
14 safety, and welfare.

15 For purposes of the program established under this
16 subsection, the term "covered prescription drug" has the
17 following meanings:

18 For Eligibility Group 1, "covered prescription drug"
19 means: (1) any cardiovascular agent or drug; (2) any
20 insulin or other prescription drug used in the treatment of
21 diabetes, including syringe and needles used to administer
22 the insulin; (3) any prescription drug used in the
23 treatment of arthritis; (4) any prescription drug used in
24 the treatment of cancer; (5) any prescription drug used in
25 the treatment of Alzheimer's disease; (6) any prescription
26 drug used in the treatment of Parkinson's disease; (7) any

1 prescription drug used in the treatment of glaucoma; (8)
2 any prescription drug used in the treatment of lung disease
3 and smoking-related illnesses; (9) any prescription drug
4 used in the treatment of osteoporosis; and (10) any
5 prescription drug used in the treatment of multiple
6 sclerosis. The Department may add additional therapeutic
7 classes by rule. The Department may adopt a preferred drug
8 list within any of the classes of drugs described in items
9 (1) through (10) of this paragraph. The specific drugs or
10 therapeutic classes of covered prescription drugs shall be
11 indicated by rule.

12 For Eligibility Group 2, "covered prescription drug"
13 means those drugs covered by the Medicare Part D
14 Prescription Drug Plan in which the beneficiary is
15 enrolled.

16 For Eligibility Group 3, "covered prescription drug"
17 means those drugs covered by the Medical Assistance Program
18 under Article V of the Illinois Public Aid Code.

19 For Eligibility Group 4, "covered prescription drug"
20 means those drugs covered by the Medicare Part D
21 Prescription Drug Plan in which the beneficiary is
22 enrolled.

23 Any person otherwise eligible for pharmaceutical
24 assistance under this subsection whose covered drugs are
25 covered by any public program is ineligible for assistance
26 under this subsection to the extent that the cost of those

1 drugs is covered by the other program.

2 The Department of Healthcare and Family Services shall
3 establish by rule the methods by which it will provide for the
4 coverage called for in this subsection. Those methods may
5 include direct reimbursement to pharmacies or the payment of a
6 capitated amount to Medicare Part D Prescription Drug Plans.

7 For a pharmacy to be reimbursed under the program
8 established under this subsection, it must comply with rules
9 adopted by the Department of Healthcare and Family Services
10 regarding coordination of benefits with Medicare Part D
11 Prescription Drug Plans. A pharmacy may not charge a
12 Medicare-enrolled beneficiary of the program established under
13 this subsection more for a covered prescription drug than the
14 appropriate Medicare cost-sharing less any payment from or on
15 behalf of the Department of Healthcare and Family Services.

16 The Department of Healthcare and Family Services or the
17 Department on Aging, as appropriate, may adopt rules regarding
18 applications, counting of income, proof of Medicare status,
19 mandatory generic policies, and pharmacy reimbursement rates
20 and any other rules necessary for the cost-efficient operation
21 of the program established under this subsection.

22 (h) A qualified individual is not entitled to duplicate
23 benefits in a coverage period as a result of the changes made
24 by this amendatory Act of the 96th General Assembly.

25 (Source: P.A. 96-804, eff. 1-1-10; 97-74, eff. 6-30-11; 97-333,
26 eff. 8-12-11.)

1 (320 ILCS 25/4.05)

2 Sec. 4.05. Application.

3 (a) The Department on Aging shall establish the content,
4 required eligibility and identification information, use of
5 social security numbers, and manner of applying for benefits in
6 a simplified format under this Act, ~~including claims filed for~~
7 ~~new or renewed prescription drug benefits.~~

8 (b) An application may be filed on paper or over the
9 Internet ~~to enable persons to apply separately or for both a~~
10 ~~property tax relief grant and pharmaceutical assistance on the~~
11 ~~same application. An application may also enable persons to~~
12 ~~apply for other State or federal programs that provide medical~~
13 ~~or pharmaceutical assistance or other benefits, as determined~~
14 ~~by the Department on Aging in conjunction with the Department~~
15 ~~of Healthcare and Family Services.~~

16 (c) Applications must be filed during the time period
17 prescribed by the Department.

18 (Source: P.A. 96-804, eff. 1-1-10.)

19 (320 ILCS 25/5) (from Ch. 67 1/2, par. 405)

20 Sec. 5. Procedure.

21 (a) In general. Claims must be filed after January 1, on
22 forms prescribed by the Department. No claim may be filed more
23 than one year after December 31 of the year for which the claim
24 is filed. ~~The pharmaceutical assistance identification card~~

1 ~~provided for in subsection (f) of Section 4 shall be valid for~~
2 ~~a period determined by the Department of Healthcare and Family~~
3 ~~Services.~~

4 (b) Claim is Personal. The right to file a claim under this
5 Act shall be personal to the claimant and shall not survive his
6 death, but such right may be exercised on behalf of a claimant
7 by his legal guardian or attorney-in-fact. If a claimant dies
8 after having filed a timely claim, the amount thereof shall be
9 disbursed to his surviving spouse or, if no spouse survives, to
10 his surviving dependent minor children in equal parts, provided
11 the spouse or child, as the case may be, resided with the
12 claimant at the time he filed his claim. If at the time of
13 disbursement neither the claimant nor his spouse is surviving,
14 and no dependent minor children of the claimant are surviving
15 the amount of the claim shall escheat to the State.

16 (c) One claim per household. Only one member of a household
17 may file a claim under this Act in any calendar year; where
18 both members of a household are otherwise entitled to claim a
19 grant under this Act, they must agree as to which of them will
20 file a claim for that year.

21 (d) (Blank).

22 (e) Pharmaceutical Assistance Procedures. Prior to July 1,
23 2012, the ~~The~~ Department of Healthcare and Family Services
24 shall determine eligibility for pharmaceutical assistance
25 using the applicant's current income. The Department shall
26 determine a person's current income in the manner provided by

1 the Department by rule.

2 (f) A person may not under any circumstances charge a fee
3 to a claimant under this Act for assistance in completing an
4 application form for a property tax relief grant ~~or~~
5 ~~pharmaceutical assistance~~ under this Act.

6 (Source: P.A. 96-491, eff. 8-14-09; 96-804, eff. 1-1-10;
7 96-1000, eff. 7-2-10.)

8 (320 ILCS 25/6) (from Ch. 67 1/2, par. 406)

9 Sec. 6. Administration.

10 (a) In general. Upon receipt of a timely filed claim, the
11 Department shall determine whether the claimant is a person
12 entitled to a grant under this Act and the amount of grant to
13 which he is entitled under this Act. The Department may require
14 the claimant to furnish reasonable proof of the statements of
15 domicile, household income, rent paid, property taxes accrued
16 and other matters on which entitlement is based, and may
17 withhold payment of a grant until such additional proof is
18 furnished.

19 (b) Rental determination. If the Department finds that the
20 gross rent used in the computation by a claimant of rent
21 constituting property taxes accrued exceeds the fair rental
22 value for the right to occupy that residence, the Department
23 may determine the fair rental value for that residence and
24 recompute rent constituting property taxes accrued
25 accordingly.

1 (c) Fraudulent claims. The Department shall deny claims
2 which have been fraudulently prepared or when it finds that the
3 claimant has acquired title to his residence or has paid rent
4 for his residence primarily for the purpose of receiving a
5 grant under this Act.

6 (d) (Blank). ~~Pharmaceutical Assistance. The Department~~
7 ~~shall allow all pharmacies licensed under the Pharmacy Practice~~
8 ~~Act to participate as authorized pharmacies unless they have~~
9 ~~been removed from that status for cause pursuant to the terms~~
10 ~~of this Section. The Director of the Department may enter into~~
11 ~~a written contract with any State agency, instrumentality or~~
12 ~~political subdivision, or a fiscal intermediary for the purpose~~
13 ~~of making payments to authorized pharmacies for covered~~
14 ~~prescription drugs and coordinating the program of~~
15 ~~pharmaceutical assistance established by this Act with other~~
16 ~~programs that provide payment for covered prescription drugs.~~
17 ~~Such agreement shall establish procedures for properly~~
18 ~~contracting for pharmacy services, validating reimbursement~~
19 ~~claims, validating compliance of dispensing pharmacists with~~
20 ~~the contracts for participation required under this Section,~~
21 ~~validating the reasonable costs of covered prescription drugs,~~
22 ~~and otherwise providing for the effective administration of~~
23 ~~this Act.~~

24 ~~The Department shall promulgate rules and regulations to~~
25 ~~implement and administer the program of pharmaceutical~~
26 ~~assistance required by this Act, which shall include the~~

1 ~~following:~~

2 ~~(1) Execution of contracts with pharmacies to dispense~~
3 ~~covered prescription drugs. Such contracts shall stipulate~~
4 ~~terms and conditions for authorized pharmacies~~
5 ~~participation and the rights of the State to terminate such~~
6 ~~participation for breach of such contract or for violation~~
7 ~~of this Act or related rules and regulations of the~~
8 ~~Department;~~

9 ~~(2) Establishment of maximum limits on the size of~~
10 ~~prescriptions, new or refilled, which shall be in amounts~~
11 ~~sufficient for 34 days, except as otherwise specified by~~
12 ~~rule for medical or utilization control reasons;~~

13 ~~(3) Establishment of liens upon any and all causes of~~
14 ~~action which accrue to a beneficiary as a result of~~
15 ~~injuries for which covered prescription drugs are directly~~
16 ~~or indirectly required and for which the Director made~~
17 ~~payment or became liable for under this Act;~~

18 ~~(4) Charge or collection of payments from third parties~~
19 ~~or private plans of assistance, or from other programs of~~
20 ~~public assistance for any claim that is properly chargeable~~
21 ~~under the assignment of benefits executed by beneficiaries~~
22 ~~as a requirement of eligibility for the pharmaceutical~~
23 ~~assistance identification card under this Act;~~

24 ~~(4.5) Provision for automatic enrollment of~~
25 ~~beneficiaries into a Medicare Discount Card program~~
26 ~~authorized under the federal Medicare Modernization Act of~~

1 ~~2003 (P.L. 108-391) to coordinate coverage including~~
2 ~~Medicare Transitional Assistance;~~

3 ~~(5) Inspection of appropriate records and audit of~~
4 ~~participating authorized pharmacies to ensure contract~~
5 ~~compliance, and to determine any fraudulent transactions~~
6 ~~or practices under this Act;~~

7 ~~(6) Annual determination of the reasonable costs of~~
8 ~~covered prescription drugs for which payments are made~~
9 ~~under this Act, as provided in Section 3.16 (now repealed);~~

10 ~~(7) Payment to pharmacies under this Act in accordance~~
11 ~~with the State Prompt Payment Act.~~

12 ~~The Department shall annually report to the Governor and~~
13 ~~the General Assembly by March 1st of each year on the~~
14 ~~administration of pharmaceutical assistance under this Act. By~~
15 ~~the effective date of this Act the Department shall determine~~
16 ~~the reasonable costs of covered prescription drugs in~~
17 ~~accordance with Section 3.16 of this Act (now repealed).~~

18 (Source: P.A. 96-328, eff. 8-11-09; 97-333, eff. 8-12-11.)

19 (320 ILCS 25/7) (from Ch. 67 1/2, par. 407)

20 Sec. 7. Payment and denial of claims.

21 (a) In general. The Director shall order the payment from
22 appropriations made for that purpose of grants to claimants
23 under this Act in the amounts to which the Department has
24 determined they are entitled, respectively. If a claim is
25 denied, the Director shall cause written notice of that denial

1 and the reasons for that denial to be sent to the claimant.

2 (b) Payment of claims one dollar and under. Where the
3 amount of the grant computed under Section 4 is less than one
4 dollar, the Department shall pay to the claimant one dollar.

5 (c) Right to appeal. Any person aggrieved by an action or
6 determination of the Department on Aging arising under any of
7 its powers or duties under this Act may request in writing that
8 the Department on Aging reconsider its action or determination,
9 setting out the facts upon which the request is based. The
10 Department on Aging shall consider the request and either
11 modify or affirm its prior action or determination. The
12 Department on Aging may adopt, by rule, procedures for
13 conducting its review under this Section.

14 ~~Any person aggrieved by an action or determination of the~~
15 ~~Department of Healthcare and Family Services arising under any~~
16 ~~of its powers or duties under this Act may request in writing~~
17 ~~that the Department of Healthcare and Family Services~~
18 ~~reconsider its action or determination, setting out the facts~~
19 ~~upon which the request is based. The Department of Healthcare~~
20 ~~and Family Services shall consider the request and either~~
21 ~~modify or affirm its prior action or determination. The~~
22 ~~Department of Healthcare and Family Services may adopt, by~~
23 ~~rule, procedures for conducting its review under this Section.~~

24 (d) (Blank).

25 (Source: P.A. 96-804, eff. 1-1-10.)

1 (320 ILCS 25/8) (from Ch. 67 1/2, par. 408)

2 Sec. 8. Records. Every claimant of a grant under this Act
3 and, prior to July 1, 2012, every applicant for pharmaceutical
4 assistance under this Act shall keep such records, render such
5 statements, file such forms and comply with such rules and
6 regulations as the Department on Aging may from time to time
7 prescribe. The Department on Aging may by regulations require
8 landlords to furnish to tenants statements as to gross rent or
9 rent constituting property taxes accrued.

10 (Source: P.A. 96-804, eff. 1-1-10.)

11 (320 ILCS 25/9) (from Ch. 67 1/2, par. 409)

12 Sec. 9. Fraud; error.

13 (a) Any person who files a fraudulent claim for a grant
14 under this Act, or who for compensation prepares a claim for a
15 grant and knowingly enters false information on an application
16 for any claimant under this Act, or who fraudulently files
17 multiple applications, or who fraudulently states that a
18 nondisabled person is disabled, or who, prior to July 1, 2012,
19 fraudulently procures pharmaceutical assistance benefits, or
20 who fraudulently uses such assistance to procure covered
21 prescription drugs, or who, on behalf of an authorized
22 pharmacy, files a fraudulent request for payment, is guilty of
23 a Class 4 felony for the first offense and is guilty of a Class
24 3 felony for each subsequent offense.

25 (b) (Blank). ~~The Department on Aging and the Department of~~

1 ~~Healthcare and Family Services shall immediately suspend the~~
2 ~~pharmaceutical assistance benefits of any person suspected of~~
3 ~~fraudulent procurement or fraudulent use of such assistance,~~
4 ~~and shall revoke such assistance upon a conviction. A person~~
5 ~~convicted of fraud under subsection (a) shall be permanently~~
6 ~~barred from all of the programs established under this Act.~~

7 (c) The Department on Aging may recover from a claimant any
8 amount paid to that claimant under this Act on account of an
9 erroneous or fraudulent claim, together with 6% interest per
10 year. Amounts recoverable from a claimant by the Department on
11 Aging under this Act may, but need not, be recovered by
12 offsetting the amount owed against any future grant payable to
13 the person under this Act.

14 The Department of Healthcare and Family Services may
15 recover for acts prior to July 1, 2012 from an authorized
16 pharmacy any amount paid to that pharmacy under the
17 pharmaceutical assistance program on account of an erroneous or
18 fraudulent request for payment under that program, together
19 with 6% interest per year. The Department of Healthcare and
20 Family Services may recover from a person who erroneously or
21 fraudulently obtains benefits under the pharmaceutical
22 assistance program the value of the benefits so obtained,
23 together with 6% interest per year.

24 (d) A prosecution for a violation of this Section may be
25 commenced at any time within 3 years of the commission of that
26 violation.

1 (Source: P.A. 96-804, eff. 1-1-10.)

2 (320 ILCS 25/12) (from Ch. 67 1/2, par. 412)

3 Sec. 12. Regulations - Department on Aging.

4 (a) Regulations. Notwithstanding any other provision to
5 the contrary, the Department on Aging may adopt rules regarding
6 applications, proof of eligibility, required identification
7 information, use of social security numbers, counting of
8 income, and a method of computing "gross rent" in the case of a
9 claimant living in a nursing or sheltered care home, and any
10 other rules necessary for the cost-efficient operation of the
11 program established under Section 4.

12 (b) The Department on Aging shall, to the extent of
13 appropriations made for that purpose:

14 (1) attempt to secure the cooperation of appropriate
15 federal, State and local agencies in securing the names and
16 addresses of persons to whom this Act pertains;

17 (2) prepare a mailing list of persons eligible for
18 grants under this Act;

19 (3) secure the cooperation of the Department of
20 Revenue, ~~the Department of Healthcare and Family Services,~~
21 other State agencies, and local business establishments to
22 facilitate distribution of applications under this Act to
23 those eligible to file claims; and

24 (4) through use of direct mail, newspaper
25 advertisements and radio and television advertisements,

1 and all other appropriate means of communication, conduct
2 an on-going public relations program to increase awareness
3 of eligible citizens of the benefits under this Act and the
4 procedures for applying for them.

5 (Source: P.A. 96-804, eff. 1-1-10.)

6 (320 ILCS 25/13) (from Ch. 67 1/2, par. 413)

7 Sec. 13. List of persons who have qualified. The Department
8 on Aging shall maintain a list of all persons who have
9 qualified under this Act and shall make the list available to
10 ~~the Department of Healthcare and Family Services,~~ the
11 Department of Public Health, the Secretary of State,
12 municipalities, and public transit authorities upon request.

13 All information received by a State agency, municipality,
14 or public transit authority under this Section shall be
15 confidential, except for official purposes, and any person who
16 divulges or uses that information in any manner, except in
17 accordance with a proper judicial order, shall be guilty of a
18 Class B misdemeanor.

19 (Source: P.A. 96-804, eff. 1-1-10.)

20 (320 ILCS 25/4.1 rep.)

21 Section 95. The Senior Citizens and Disabled Persons
22 Property Tax Relief and Pharmaceutical Assistance Act is
23 amended by repealing Section 4.1.

1 Section 100. The Sexual Assault Survivors Emergency
2 Treatment Act is amended by changing Section 7 as follows:

3 (410 ILCS 70/7) (from Ch. 111 1/2, par. 87-7)

4 Sec. 7. Reimbursement ~~Charges and reimbursement.~~

5 (a) When any ambulance provider furnishes transportation,
6 hospital provides hospital emergency services and forensic
7 services, hospital or health care professional or laboratory
8 provides follow-up healthcare, or pharmacy dispenses
9 prescribed medications to any sexual assault survivor, as
10 defined by the Department of Healthcare and Family Services,
11 who is neither eligible to receive such services under the
12 Illinois Public Aid Code nor covered as to such services by a
13 policy of insurance, the ambulance provider, hospital, health
14 care professional, pharmacy, or laboratory shall furnish such
15 services to that person without charge and shall be entitled to
16 be reimbursed for ~~its billed charges in~~ providing such services
17 by the Illinois Sexual Assault Emergency Treatment Program
18 under the Department of Healthcare and Family Services.
19 ~~Pharmacies shall dispense prescribed medications without~~
20 ~~charge to the survivor and shall be reimbursed~~ and at the
21 Department of Healthcare and Family Services' ~~Medicaid~~
22 allowable rates under the Illinois Public Aid Code.

23 (b) The hospital is responsible for submitting the request
24 for reimbursement for ambulance services, hospital emergency
25 services, and forensic services to the Illinois Sexual Assault

1 Emergency Treatment Program. Nothing in this Section precludes
2 hospitals from providing follow-up healthcare and receiving
3 reimbursement under this Section.

4 (c) The health care professional who provides follow-up
5 healthcare and the pharmacy that dispenses prescribed
6 medications to a sexual assault survivor are responsible for
7 submitting the request for reimbursement for follow-up
8 healthcare or pharmacy services to the Illinois Sexual Assault
9 Emergency Treatment Program.

10 (d) On and after July 1, 2012, the Department shall reduce
11 any rate of reimbursement for services or other payments or
12 alter any methodologies authorized by this Act or the Illinois
13 Public Aid Code to reduce any rate of reimbursement for
14 services or other payments in accordance with Section 5-5e of
15 the Illinois Public Aid Code.

16 (d) The Department of Healthcare and Family Services shall
17 establish standards, rules, and regulations to implement this
18 Section.

19 (Source: P.A. 95-331, eff. 8-21-07; 95-432, eff. 1-1-08.)

20 Section 102. The Hemophilia Care Act is amended by changing
21 Section 3 as follows:

22 (410 ILCS 420/3) (from Ch. 111 1/2, par. 2903)

23 Sec. 3. The powers and duties of the Department shall
24 include the following:

1 (1) With the advice and counsel of the Committee,
2 develop standards for determining eligibility for care and
3 treatment under this program. Among other standards
4 developed under this Section, persons suffering from
5 hemophilia must be evaluated in a center properly staffed
6 and equipped for such evaluation, but not operated by the
7 Department.

8 (2) (Blank).

9 (3) Extend financial assistance to eligible persons in
10 order that they may obtain blood and blood derivatives for
11 use in hospitals, in medical and dental facilities, or at
12 home. The Department shall extend financial assistance in
13 each fiscal year to each family containing one or more
14 eligible persons in the amount of (a) the family's eligible
15 cost of hemophilia services for that fiscal year, minus (b)
16 one fifth of its available family income for its next
17 preceding taxable year. The Director may extend financial
18 assistance in the case of unusual hardships, according to
19 specific procedures and conditions adopted for this
20 purpose in the rules and regulations promulgated by the
21 Department to implement and administer this Act.

22 (4) (Blank).

23 (5) Promulgate rules and regulations with the advice
24 and counsel of the Committee for the implementation and
25 administration of this Act.

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

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

6 (Source: P.A. 89-507, eff. 7-1-97; 90-587, eff. 7-1-98.)

7 Section 103. The Renal Disease Treatment Act is amended by
8 changing Section 3 as follows:

9 (410 ILCS 430/3) (from Ch. 111 1/2, par. 22.33)

10 Sec. 3. Duties of Departments of Healthcare and Family
11 Services and Public Health.

12 (A) The Department of Healthcare and Family Services shall:

13 (a) With the advice of the Renal Disease Advisory
14 Committee, develop standards for determining eligibility
15 for care and treatment under this program. Among other
16 standards so developed under this paragraph, candidates,
17 to be eligible for care and treatment, must be evaluated in
18 a center properly staffed and equipped for such evaluation.

19 (b) (Blank).

20 (c) (Blank).

21 (d) Extend financial assistance to persons suffering
22 from chronic renal diseases in obtaining the medical,
23 surgical, nursing, pharmaceutical, and technical services
24 necessary in caring for such diseases, including the

1 renting of home dialysis equipment. The Renal Disease
2 Advisory Committee shall recommend to the Department the
3 extent of financial assistance, including the reasonable
4 charges and fees, for:

5 (1) Treatment in a dialysis facility;

6 (2) Hospital treatment for dialysis and transplant
7 surgery;

8 (3) Treatment in a limited care facility;

9 (4) Home dialysis training; and

10 (5) Home dialysis.

11 (e) Assist in equipping dialysis centers.

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

18 (B) The Department of Public Health shall:

19 (a) Assist in the development and expansion of programs
20 for the care and treatment of persons suffering from
21 chronic renal diseases, including dialysis and other
22 medical or surgical procedures and techniques that will
23 have a lifesaving effect in the care and treatment of
24 persons suffering from these diseases.

25 (b) Assist in the development of programs for the
26 prevention of chronic renal diseases.

1 (c) Institute and carry on an educational program among
2 physicians, hospitals, public health departments, and the
3 public concerning chronic renal diseases, including the
4 dissemination of information and the conducting of
5 educational programs concerning the prevention of chronic
6 renal diseases and the methods for the care and treatment
7 of persons suffering from these diseases.

8 (Source: P.A. 95-331, eff. 8-21-07.)

9 Section 104. The Code of Civil Procedure is amended by
10 changing Section 5-105 as follows:

11 (735 ILCS 5/5-105) (from Ch. 110, par. 5-105)

12 Sec. 5-105. Leave to sue or defend as an indigent person.

13 (a) As used in this Section:

14 (1) "Fees, costs, and charges" means payments imposed
15 on a party in connection with the prosecution or defense of
16 a civil action, including, but not limited to: filing fees;
17 appearance fees; fees for service of process and other
18 papers served either within or outside this State,
19 including service by publication pursuant to Section 2-206
20 of this Code and publication of necessary legal notices;
21 motion fees; jury demand fees; charges for participation
22 in, or attendance at, any mandatory process or procedure
23 including, but not limited to, conciliation, mediation,
24 arbitration, counseling, evaluation, "Children First",

1 "Focus on Children" or similar programs; fees for
2 supplementary proceedings; charges for translation
3 services; guardian ad litem fees; charges for certified
4 copies of court documents; and all other processes and
5 procedures deemed by the court to be necessary to commence,
6 prosecute, defend, or enforce relief in a civil action.

7 (2) "Indigent person" means any person who meets one or
8 more of the following criteria:

9 (i) He or she is receiving assistance under one or
10 more of the following public benefits programs:
11 Supplemental Security Income (SSI), Aid to the Aged,
12 Blind and Disabled (AABD), Temporary Assistance for
13 Needy Families (TANF), Food Stamps, General
14 Assistance, ~~State~~ Transitional Assistance, or State
15 Children and Family Assistance.

16 (ii) His or her available income is 125% or less of
17 the current poverty level as established by the United
18 States Department of Health and Human Services, unless
19 the applicant's assets that are not exempt under Part 9
20 or 10 of Article XII of this Code are of a nature and
21 value that the court determines that the applicant is
22 able to pay the fees, costs, and charges.

23 (iii) He or she is, in the discretion of the court,
24 unable to proceed in an action without payment of fees,
25 costs, and charges and whose payment of those fees,
26 costs, and charges would result in substantial

1 hardship to the person or his or her family.

2 (iv) He or she is an indigent person pursuant to
3 Section 5-105.5 of this Code.

4 (b) On the application of any person, before, or after the
5 commencement of an action, a court, on finding that the
6 applicant is an indigent person, shall grant the applicant
7 leave to sue or defend the action without payment of the fees,
8 costs, and charges of the action.

9 (c) An application for leave to sue or defend an action as
10 an indigent person shall be in writing and supported by the
11 affidavit of the applicant or, if the applicant is a minor or
12 an incompetent adult, by the affidavit of another person having
13 knowledge of the facts. The contents of the affidavit shall be
14 established by Supreme Court Rule. The court shall provide,
15 through the office of the clerk of the court, simplified forms
16 consistent with the requirements of this Section and applicable
17 Supreme Court Rules to any person seeking to sue or defend an
18 action who indicates an inability to pay the fees, costs, and
19 charges of the action. The application and supporting affidavit
20 may be incorporated into one simplified form. The clerk of the
21 court shall post in a conspicuous place in the courthouse a
22 notice no smaller than 8.5 x 11 inches, using no smaller than
23 30-point typeface printed in English and in Spanish, advising
24 the public that they may ask the court for permission to sue or
25 defend a civil action without payment of fees, costs, and
26 charges. The notice shall be substantially as follows:

1 "If you are unable to pay the fees, costs, and charges
2 of an action you may ask the court to allow you to proceed
3 without paying them. Ask the clerk of the court for forms."

4 (d) The court shall rule on applications under this Section
5 in a timely manner based on information contained in the
6 application unless the court, in its discretion, requires the
7 applicant to personally appear to explain or clarify
8 information contained in the application. If the court finds
9 that the applicant is an indigent person, the court shall enter
10 an order permitting the applicant to sue or defend without
11 payment of fees, costs, or charges. If the application is
12 denied, the court shall enter an order to that effect stating
13 the specific reasons for the denial. The clerk of the court
14 shall promptly mail or deliver a copy of the order to the
15 applicant.

16 (e) The clerk of the court shall not refuse to accept and
17 file any complaint, appearance, or other paper presented by the
18 applicant if accompanied by an application to sue or defend in
19 forma pauperis, and those papers shall be considered filed on
20 the date the application is presented. If the application is
21 denied, the order shall state a date certain by which the
22 necessary fees, costs, and charges must be paid. The court, for
23 good cause shown, may allow an applicant whose application is
24 denied to defer payment of fees, costs, and charges, make
25 installment payments, or make payment upon reasonable terms and
26 conditions stated in the order. The court may dismiss the

1 claims or defenses of any party failing to pay the fees, costs,
2 or charges within the time and in the manner ordered by the
3 court. A determination concerning an application to sue or
4 defend in forma pauperis shall not be construed as a ruling on
5 the merits.

6 (f) The court may order an indigent person to pay all or a
7 portion of the fees, costs, or charges waived pursuant to this
8 Section out of moneys recovered by the indigent person pursuant
9 to a judgment or settlement resulting from the civil action.
10 However, nothing in ~~is~~ this Section shall be construed to limit
11 the authority of a court to order another party to the action
12 to pay the fees, costs, or charges of the action.

13 (g) A court, in its discretion, may appoint counsel to
14 represent an indigent person, and that counsel shall perform
15 his or her duties without fees, charges, or reward.

16 (h) Nothing in this Section shall be construed to affect
17 the right of a party to sue or defend an action in forma
18 pauperis without the payment of fees, costs, or charges, or the
19 right of a party to court-appointed counsel, as authorized by
20 any other provision of law or by the rules of the Illinois
21 Supreme Court.

22 (i) The provisions of this Section are severable under
23 Section 1.31 of the Statute on Statutes.

24 (Source: P.A. 91-621, eff. 8-19-99; revised 11-21-11.)

25 Section 105. The Unemployment Insurance Act is amended by

1 changing Sections 1400.2, 1402, 1404, 1405, 1801.1, and 1900 as
2 follows:

3 (820 ILCS 405/1400.2)

4 Sec. 1400.2. Annual reporting and paying; household
5 workers. This Section applies to an employer who solely employs
6 one or more household workers with respect to whom the employer
7 files federal unemployment taxes as part of his or her federal
8 income tax return, or could file federal unemployment taxes as
9 part of his or her federal income tax return if the worker or
10 workers were providing services in employment for purposes of
11 the federal unemployment tax. For purposes of this Section,
12 "household worker" has the meaning ascribed to it for purposes
13 of Section 3510 of the federal Internal Revenue Code. If an
14 employer to whom this Section applies notifies the Director, in
15 writing, that he or she wishes to pay his or her contributions
16 for each quarter and submit his or her wage ~~and contribution~~
17 reports for each month or quarter, as the case may be, on an
18 annual basis, then the due date for filing the reports and
19 paying the contributions shall be April 15 of the calendar year
20 immediately following the close of the months or quarters to
21 which the reports and quarters to which the contributions
22 apply, except that the Director may, by rule, establish a
23 different due date for good cause.

24 (Source: P.A. 94-723, eff. 1-19-06.)

1 (820 ILCS 405/1402) (from Ch. 48, par. 552)

2 Sec. 1402. Penalties.

3 A. If any employer fails, within the time prescribed in
4 this Act as amended and in effect on October 5, 1980, and the
5 regulations of the Director, to file a report of wages paid to
6 each of his workers, or to file a sufficient report of such
7 wages after having been notified by the Director to do so, for
8 any period which begins prior to January 1, 1982, he shall pay
9 to the Director as a penalty a sum determined in accordance
10 with the provisions of this Act as amended and in effect on
11 October 5, 1980.

12 B. Except as otherwise provided in this Section, any
13 employer who fails to file a report of wages paid to each of
14 his workers for any period which begins on or after January 1,
15 1982, within the time prescribed by the provisions of this Act
16 and the regulations of the Director, or, if the Director
17 pursuant to such regulations extends the time for filing the
18 report, fails to file it within the extended time, shall, in
19 addition to any sum otherwise payable by him under the
20 provisions of this Act, pay to the Director as a penalty a sum
21 equal to the lesser of (1) \$5 for each \$10,000 or fraction
22 thereof of the total wages for insured work paid by him during
23 the period or (2) \$2,500, for each month or part thereof of
24 such failure to file the report. With respect to an employer
25 who has elected to file reports of wages on an annual basis
26 pursuant to Section 1400.2, in assessing penalties for the

1 failure to submit all reports by the due date established
2 pursuant to that Section, the 30-day period immediately
3 following the due date shall be considered as one month.

4 If the Director deems an employer's report of wages paid to
5 each of his workers for any period which begins on or after
6 January 1, 1982, insufficient, he shall notify the employer to
7 file a sufficient report. If the employer fails to file such
8 sufficient report within 30 days after the mailing of the
9 notice to him, he shall, in addition to any sum otherwise
10 payable by him under the provisions of this Act, pay to the
11 Director as a penalty a sum determined in accordance with the
12 provisions of the first paragraph of this subsection, for each
13 month or part thereof of such failure to file such sufficient
14 report after the date of the notice.

15 For wages paid in calendar years prior to 1988, the penalty
16 or penalties which accrue under the two foregoing paragraphs
17 with respect to a report for any period shall not be less than
18 \$100, and shall not exceed the lesser of (1) \$10 for each
19 \$10,000 or fraction thereof of the total wages for insured work
20 paid during the period or (2) \$5,000. For wages paid in
21 calendar years after 1987, the penalty or penalties which
22 accrue under the 2 foregoing paragraphs with respect to a
23 report for any period shall not be less than \$50, and shall not
24 exceed the lesser of (1) \$10 for each \$10,000 or fraction of
25 the total wages for insured work paid during the period or (2)
26 \$5,000. With respect to an employer who has elected to file

1 reports of wages on an annual basis pursuant to Section 1400.2,
2 for purposes of calculating the minimum penalty prescribed by
3 this Section for failure to file the reports on a timely basis,
4 a calendar year shall constitute a single period. For reports
5 of wages paid after 1986, the Director shall not, however,
6 impose a penalty pursuant to either of the two foregoing
7 paragraphs on any employer who can prove within 30 working days
8 after the mailing of a notice of his failure to file such a
9 report, that (1) the failure to file the report is his first
10 such failure during the previous 20 consecutive calendar
11 quarters, and (2) the amount of the total contributions due for
12 the calendar quarter of such report (or, in the case of an
13 employer who is required to file the reports on a monthly
14 basis, the amount of the total contributions due for the
15 calendar quarter that includes the month of such report) is
16 less than \$500.

17 Except as otherwise provided in this Section, for any month
18 which begins on or after July 1, 2012, a report of the wages
19 paid to each of an employer's workers shall be due on or before
20 the last day of the month next following the calendar month in
21 which the wages were paid. In the case of an employer who
22 reported wages paid for a total of at least one but fewer than
23 5 workers for the immediately preceding calendar year, a report
24 of the wages paid to each of the employer's workers shall be
25 due on or before the last day of the month next following the
26 calendar quarter in which the wages were paid.

1 Any employer who wilfully fails to pay any contribution or
2 part thereof, based upon wages paid prior to 1987, when
3 required by the provisions of this Act and the regulations of
4 the Director, with intent to defraud the Director, shall in
5 addition to such contribution or part thereof pay to the
6 Director a penalty equal to 50 percent of the amount of such
7 contribution or part thereof, as the case may be, provided that
8 the penalty shall not be less than \$200.

9 Any employer who willfully fails to pay any contribution or
10 part thereof, based upon wages paid in 1987 and in each
11 calendar year thereafter, when required by the provisions of
12 this Act and the regulations of the Director, with intent to
13 defraud the Director, shall in addition to such contribution or
14 part thereof pay to the Director a penalty equal to 60% of the
15 amount of such contribution or part thereof, as the case may
16 be, provided that the penalty shall not be less than \$400.

17 However, all or part of any penalty may be waived by the
18 Director for good cause shown.

19 (Source: P.A. 94-723, eff. 1-19-06.)

20 (820 ILCS 405/1404) (from Ch. 48, par. 554)

21 Sec. 1404. Payments in lieu of contributions by nonprofit
22 organizations. A. For the year 1972 and for each calendar year
23 thereafter, contributions shall accrue and become payable,
24 pursuant to Section 1400, by each nonprofit organization
25 (defined in Section 211.2) upon the wages paid by it with

1 respect to employment after 1971, unless the nonprofit
2 organization elects, in accordance with the provisions of this
3 Section, to pay, in lieu of contributions, an amount equal to
4 the amount of regular benefits and one-half the amount of
5 extended benefits (defined in Section 409) paid to individuals,
6 for any weeks which begin on or after the effective date of the
7 election, on the basis of wages for insured work paid to them
8 by such nonprofit organization during the effective period of
9 such election. Notwithstanding the preceding provisions of
10 this subsection and the provisions of subsection D, with
11 respect to benefit years beginning prior to July 1, 1989, any
12 adjustment after September 30, 1989 to the base period wages
13 paid to the individual by any employer shall not affect the
14 ratio for determining the payments in lieu of contributions of
15 a nonprofit organization which has elected to make payments in
16 lieu of contributions. Provided, however, that with respect to
17 benefit years beginning on or after July 1, 1989, the nonprofit
18 organization shall be required to make payments equal to 100%
19 of regular benefits, including dependents' allowances, and 50%
20 of extended benefits, including dependents' allowances, paid
21 to an individual with respect to benefit years beginning during
22 the effective period of the election, but only if the nonprofit
23 organization: (a) is the last employer as provided in Section
24 1502.1 and (b) paid to the individual receiving benefits, wages
25 for insured work during his base period. If the nonprofit
26 organization described in this paragraph meets the

1 requirements of (a) but not (b), with respect to benefit years
2 beginning on or after July 1, 1989, it shall be required to
3 make payments in an amount equal to 50% of regular benefits,
4 including dependents' allowances, and 25% of extended
5 benefits, including dependents' allowances, paid to an
6 individual with respect to benefit years beginning during the
7 effective period of the election.

8 1. Any employing unit which becomes a nonprofit
9 organization on January 1, 1972, may elect to make payments in
10 lieu of contributions for not less than one calendar year
11 beginning with January 1, 1972, provided that it files its
12 written election with the Director not later than January 31,
13 1972.

14 2. Any employing unit which becomes a nonprofit
15 organization after January 1, 1972, may elect to make payments
16 in lieu of contributions for a period of not less than one
17 calendar year beginning as of the first day with respect to
18 which it would, in the absence of its election, incur liability
19 for the payment of contributions, provided that it files its
20 written election with the Director not later than 30 days
21 immediately following the end of the calendar quarter in which
22 it becomes a nonprofit organization.

23 3. A nonprofit organization which has incurred liability
24 for the payment of contributions for at least 2 calendar years
25 and is not delinquent in such payment and in the payment of any
26 interest or penalties which may have accrued, may elect to make

1 payments in lieu of contributions beginning January 1 of any
2 calendar year, provided that it files its written election with
3 the Director prior to such January 1, and provided, further,
4 that such election shall be for a period of not less than 2
5 calendar years.

6 4. An election to make payments in lieu of contributions
7 shall not terminate any liability incurred by an employer for
8 the payment of contributions, interest or penalties with
9 respect to any calendar quarter (or month, as the case may be)
10 which ends prior to the effective period of the election.

11 5. A nonprofit organization which has elected, pursuant to
12 paragraph 1, 2, or 3, to make payments in lieu of contributions
13 may terminate the effective period of the election as of
14 January 1 of any calendar year subsequent to the required
15 minimum period of the election only if, prior to such January
16 1, it files with the Director a written notice to that effect.
17 Upon such termination, the organization shall become liable for
18 the payment of contributions upon wages for insured work paid
19 by it on and after such January 1 and, notwithstanding such
20 termination, it shall continue to be liable for payments in
21 lieu of contributions with respect to benefits paid to
22 individuals on and after such January 1, with respect to
23 benefit years beginning prior to July 1, 1989, on the basis of
24 wages for insured work paid to them by the nonprofit
25 organization prior to such January 1, and, with respect to
26 benefit years beginning after June 30, 1989, if such employer

1 was the last employer as provided in Section 1502.1 during a
2 benefit year beginning prior to such January 1.

3 6. Written elections to make payments in lieu of
4 contributions and written notices of termination of election
5 shall be filed in such form and shall contain such information
6 as the Director may prescribe. Upon the filing of such election
7 or notice, the Director shall either order it approved, or, if
8 it appears to the Director that the nonprofit organization has
9 not filed such election or notice within the time prescribed,
10 he shall order it disapproved. The Director shall serve notice
11 of his order upon the nonprofit organization. The Director's
12 order shall be final and conclusive upon the nonprofit
13 organization unless, within 15 days after the date of mailing
14 of notice thereof, the nonprofit organization files with the
15 Director an application for its review, setting forth its
16 reasons in support thereof. Upon receipt of an application for
17 review within the time prescribed, the Director shall order it
18 allowed, or shall order that it be denied, and shall serve
19 notice upon the nonprofit organization of his order. All of the
20 provisions of Section 1509, applicable to orders denying
21 applications for review of determinations of employers' rates
22 of contribution and not inconsistent with the provisions of
23 this subsection, shall be applicable to an order denying an
24 application for review filed pursuant to this subsection.

25 B. As soon as practicable following the close of each
26 calendar quarter, the Director shall mail to each nonprofit

1 organization which has elected to make payments in lieu of
2 contributions a Statement of the amount due from it for the
3 regular and one-half the extended benefits paid (or the amounts
4 otherwise provided for in subsection A) during the calendar
5 quarter, together with the names of its workers or former
6 workers and the amounts of benefits paid to each of them during
7 the calendar quarter, with respect to benefit years beginning
8 prior to July 1, 1989, on the basis of wages for insured work
9 paid to them by the nonprofit organization; or, with respect to
10 benefit years beginning after June 30, 1989, if such nonprofit
11 organization was the last employer as provided in Section
12 1502.1 with respect to a benefit year beginning during the
13 effective period of the election. The amount due shall be
14 payable, and the nonprofit organization shall make payment of
15 such amount not later than 30 days after the date of mailing of
16 the Statement. The Statement shall be final and conclusive upon
17 the nonprofit organization unless, within 20 days after the
18 date of mailing of the Statement, the nonprofit organization
19 files with the Director an application for revision thereof.
20 Such application shall specify wherein the nonprofit
21 organization believes the Statement to be incorrect, and shall
22 set forth its reasons for such belief. All of the provisions of
23 Section 1508, applicable to applications for revision of
24 Statements of Benefit Wages and Statements of Benefit Charges
25 and not inconsistent with the provisions of this subsection,
26 shall be applicable to an application for revision of a

1 Statement filed pursuant to this subsection.

2 1. Payments in lieu of contributions made by any nonprofit
3 organization shall not be deducted or deductible, in whole or
4 in part, from the remuneration of individuals in the employ of
5 the organization, nor shall any nonprofit organization require
6 or accept any waiver of any right under this Act by an
7 individual in its employ. The making of any such deduction or
8 the requirement or acceptance of any such waiver is a Class A
9 misdemeanor. Any agreement by an individual in the employ of
10 any person or concern to pay all or any portion of a payment in
11 lieu of contributions, required under this Act from a nonprofit
12 organization, is void.

13 2. A nonprofit organization which fails to make any payment
14 in lieu of contributions when due under the provisions of this
15 subsection shall pay interest thereon at the rates specified in
16 Section 1401. A nonprofit organization which has elected to
17 make payments in lieu of contributions shall be subject to the
18 penalty provisions of Section 1402. In the making of any
19 payment in lieu of contributions or in the payment of any
20 interest or penalties, a fractional part of a cent shall be
21 disregarded unless it amounts to one-half cent or more, in
22 which case it shall be increased to one cent.

23 3. All of the remedies available to the Director under the
24 provisions of this Act or of any other law to enforce the
25 payment of contributions, interest, or penalties under this
26 Act, including the making of determinations and assessments

1 pursuant to Section 2200, are applicable to the enforcement of
2 payments in lieu of contributions and of interest and
3 penalties, due under the provisions of this Section. For the
4 purposes of this paragraph, the term "contribution" or
5 "contributions" which appears in any such provision means
6 "payment in lieu of contributions" or "payments in lieu of
7 contributions." The term "contribution" which appears in
8 Section 2800 also means "payment in lieu of contributions."

9 4. All of the provisions of Sections 2201 and 2201.1,
10 applicable to adjustment or refund of contributions, interest
11 and penalties erroneously paid and not inconsistent with the
12 provisions of this Section, shall be applicable to payments in
13 lieu of contributions erroneously made or interest or penalties
14 erroneously paid by a nonprofit organization.

15 5. Payment in lieu of contributions shall be due with
16 respect to any sum erroneously paid as benefits to an
17 individual unless such sum has been recouped pursuant to
18 Section 900 or has otherwise been recovered. If such payment in
19 lieu of contributions has been made, the amount thereof shall
20 be adjusted or refunded in accordance with the provisions of
21 paragraph 4 and Section 2201 if recoupment or other recovery
22 has been made.

23 6. A nonprofit organization which has elected to make
24 payments in lieu of contributions and thereafter ceases to be
25 an employer shall continue to be liable for payments in lieu of
26 contributions with respect to benefits paid to individuals on

1 and after the date it has ceased to be an employer, with
2 respect to benefit years beginning prior to July 1, 1989, on
3 the basis of wages for insured work paid to them by it prior to
4 the date it ceased to be an employer, and, with respect to
5 benefit years beginning after June 30, 1989, if such employer
6 was the last employer as provided in Section 1502.1 prior to
7 the date that it ceased to be an employer.

8 7. With respect to benefit years beginning prior to July 1,
9 1989, wages paid to an individual during his base period, by a
10 nonprofit organization which elects to make payments in lieu of
11 contributions, for less than full time work, performed during
12 the same weeks in the base period during which the individual
13 had other insured work, shall not be subject to payments in
14 lieu of contributions (upon such employer's request pursuant to
15 the regulation of the Director) so long as the employer
16 continued after the end of the base period, and continues
17 during the applicable benefit year, to furnish such less than
18 full time work to the individual on the same basis and in
19 substantially the same amount as during the base period. If the
20 individual is paid benefits with respect to a week (in the
21 applicable benefit year) after the employer has ceased to
22 furnish the work hereinabove described, the nonprofit
23 organization shall be liable for payments in lieu of
24 contributions with respect to the benefits paid to the
25 individual after the date on which the nonprofit organization
26 ceases to furnish the work.

1 C. With respect to benefit years beginning prior to July 1,
2 1989, whenever benefits have been paid to an individual on the
3 basis of wages for insured work paid to him by a nonprofit
4 organization, and the organization incurred liability for the
5 payment of contributions on some of the wages because only a
6 part of the individual's base period was within the effective
7 period of the organization's written election to make payments
8 in lieu of contributions, the organization shall pay an amount
9 in lieu of contributions which bears the same ratio to the
10 total benefits paid to the individual as the total wages for
11 insured work paid to him during the base period by the
12 organization upon which it did not incur liability for the
13 payment of contributions (for the aforesaid reason) bear to the
14 total wages for insured work paid to the individual during the
15 base period by the organization.

16 D. With respect to benefit years beginning prior to July 1,
17 1989, whenever benefits have been paid to an individual on the
18 basis of wages for insured work paid to him by a nonprofit
19 organization which has elected to make payments in lieu of
20 contributions, and by one or more other employers, the
21 nonprofit organization shall pay an amount in lieu of
22 contributions which bears the same ratio to the total benefits
23 paid to the individual as the wages for insured work paid to
24 the individual during his base period by the nonprofit
25 organization bear to the total wages for insured work paid to
26 the individual during the base period by all of the employers.

1 If the nonprofit organization incurred liability for the
2 payment of contributions on some of the wages for insured work
3 paid to the individual, it shall be treated, with respect to
4 such wages, as one of the other employers for the purposes of
5 this paragraph.

6 E. Two or more nonprofit organizations which have elected
7 to make payments in lieu of contributions may file a joint
8 application with the Director for the establishment of a group
9 account, effective January 1 of any calendar year, for the
10 purpose of sharing the cost of benefits paid on the basis of
11 the wages for insured work paid by such nonprofit
12 organizations, provided that such joint application is filed
13 with the Director prior to such January 1. The application
14 shall identify and authorize a group representative to act as
15 the group's agent for the purposes of this paragraph, and shall
16 be filed in such form and shall contain such information as the
17 Director may prescribe. Upon his approval of a joint
18 application, the Director shall, by order, establish a group
19 account for the applicants and shall serve notice upon the
20 group's representative of such order. Such account shall remain
21 in effect for not less than 2 calendar years and thereafter
22 until terminated by the Director for good cause or, as of the
23 close of any calendar quarter, upon application by the group.
24 Upon establishment of the account, the group shall be liable to
25 the Director for payments in lieu of contributions in an amount
26 equal to the total amount for which, in the absence of the

1 group account, liability would have been incurred by all of its
2 members; provided, with respect to benefit years beginning
3 prior to July 1, 1989, that the liability of any member to the
4 Director with respect to any payment in lieu of contributions,
5 interest or penalties not paid by the group when due with
6 respect to any calendar quarter shall be in an amount which
7 bears the same ratio to the total benefits paid during such
8 quarter on the basis of the wages for insured work paid by all
9 members of the group as the total wages for insured work paid
10 by such member during such quarter bear to the total wages for
11 insured work paid during the quarter by all members of the
12 group, and, with respect to benefit years beginning on or after
13 July 1, 1989, that the liability of any member to the Director
14 with respect to any payment in lieu of contributions, interest
15 or penalties not paid by the group when due with respect to any
16 calendar quarter shall be in an amount which bears the same
17 ratio to the total benefits paid during such quarter to
18 individuals with respect to whom any member of the group was
19 the last employer as provided in Section 1502.1 as the total
20 wages for insured work paid by such member during such quarter
21 bear to the total wages for insured work paid during the
22 quarter by all members of the group. With respect to calendar
23 months and quarters beginning on or after July 1, 2012, the
24 liability of any member to the Director with respect to any
25 penalties that are assessed for failure to file a timely and
26 sufficient report of wages and which are not paid by the group

1 when due with respect to the calendar month or quarter, as the
2 case may be, shall be in an amount which bears the same ratio
3 to the total penalties due with respect to such month or
4 quarter as the total wages for insured work paid by such member
5 during such month or quarter bear to the total wages for
6 insured work paid during the month or quarter by all members of
7 the group. All of the provisions of this Section applicable to
8 nonprofit organizations which have elected to make payments in
9 lieu of contributions, and not inconsistent with the provisions
10 of this paragraph, shall apply to a group account and, upon its
11 termination, to each former member thereof. The Director shall
12 by regulation prescribe the conditions for establishment,
13 maintenance and termination of group accounts, and for addition
14 of new members to and withdrawal of active members from such
15 accounts.

16 F. Whenever service of notice is required by this Section,
17 such notice may be given and be complete by depositing it with
18 the United States Mail, addressed to the nonprofit organization
19 (or, in the case of a group account, to its representative) at
20 its last known address. If such organization is represented by
21 counsel in proceedings before the Director, service of notice
22 may be made upon the nonprofit organization by mailing the
23 notice to such counsel.

24 (Source: P.A. 86-3.)

1 Sec. 1405. Financing Benefits for Employees of Local
2 Governments.

3 A. 1. For the year 1978 and for each calendar year
4 thereafter, contributions shall accrue and become payable,
5 pursuant to Section 1400, by each governmental entity (other
6 than the State of Illinois and its wholly owned
7 instrumentalities) referred to in clause (B) of Section 211.1,
8 upon the wages paid by such entity with respect to employment
9 after 1977, unless the entity elects to make payments in lieu
10 of contributions pursuant to the provisions of subsection B.
11 Notwithstanding the provisions of Sections 1500 to 1510,
12 inclusive, a governmental entity which has not made such
13 election shall, for liability for contributions incurred prior
14 to January 1, 1984, pay contributions equal to 1 percent with
15 respect to wages for insured work paid during each such
16 calendar year or portion of such year as may be applicable. As
17 used in this subsection, the word "wages", defined in Section
18 234, is subject to all of the provisions of Section 235.

19 2. An Indian tribe for which service is exempted from the
20 federal unemployment tax under Section 3306(c)(7) of the
21 Federal Unemployment Tax Act may elect to make payments in lieu
22 of contributions in the same manner and subject to the same
23 conditions as provided in this Section with regard to
24 governmental entities, except as otherwise provided in
25 paragraphs 7, 8, and 9 of subsection B.

26 B. Any governmental entity subject to subsection A may

1 elect to make payments in lieu of contributions, in amounts
2 equal to the amounts of regular and extended benefits paid to
3 individuals, for any weeks which begin on or after the
4 effective date of the election, on the basis of wages for
5 insured work paid to them by the entity during the effective
6 period of such election. Notwithstanding the preceding
7 provisions of this subsection and the provisions of subsection
8 D of Section 1404, with respect to benefit years beginning
9 prior to July 1, 1989, any adjustment after September 30, 1989
10 to the base period wages paid to the individual by any employer
11 shall not affect the ratio for determining payments in lieu of
12 contributions of a governmental entity which has elected to
13 make payments in lieu of contributions. Provided, however, that
14 with respect to benefit years beginning on or after July 1,
15 1989, the governmental entity shall be required to make
16 payments equal to 100% of regular benefits, including
17 dependents' allowances, and 100% of extended benefits,
18 including dependents' allowances, paid to an individual with
19 respect to benefit years beginning during the effective period
20 of the election, but only if the governmental entity: (a) is
21 the last employer as provided in Section 1502.1 and (b) paid to
22 the individual receiving benefits, wages for insured work
23 during his base period. If the governmental entity described in
24 this paragraph meets the requirements of (a) but not (b), with
25 respect to benefit years beginning on or after July 1, 1989, it
26 shall be required to make payments in an amount equal to 50% of

1 regular benefits, including dependents' allowances, and 50% of
2 extended benefits, including dependents' allowances, paid to
3 an individual with respect to benefit years beginning during
4 the effective period of the election.

5 1. Any such governmental entity which becomes an employer
6 on January 1, 1978 pursuant to Section 205 may elect to make
7 payments in lieu of contributions for not less than one
8 calendar year beginning with January 1, 1978, provided that it
9 files its written election with the Director not later than
10 January 31, 1978.

11 2. A governmental entity newly created after January 1,
12 1978, may elect to make payments in lieu of contributions for a
13 period of not less than one calendar year beginning as of the
14 first day with respect to which it would, in the absence of its
15 election, incur liability for the payment of contributions,
16 provided that it files its written election with the Director
17 not later than 30 days immediately following the end of the
18 calendar quarter in which it has been created.

19 3. A governmental entity which has incurred liability for
20 the payment of contributions for at least 2 calendar years, and
21 is not delinquent in such payment and in the payment of any
22 interest or penalties which may have accrued, may elect to make
23 payments in lieu of contributions beginning January 1 of any
24 calendar year, provided that it files its written election with
25 the Director prior to such January 1, and provided, further,
26 that such election shall be for a period of not less than 2

1 calendar years.

2 4. An election to make payments in lieu of contributions
3 shall not terminate any liability incurred by a governmental
4 entity for the payment of contributions, interest or penalties
5 with respect to any calendar quarter (or month, as the case may
6 be) which ends prior to the effective period of the election.

7 5. The termination by a governmental entity of the
8 effective period of its election to make payments in lieu of
9 contributions, and the filing of and subsequent action upon
10 written notices of termination of election, shall be governed
11 by the provisions of paragraphs 5 and 6 of Section 1404A,
12 pertaining to nonprofit organizations.

13 6. With respect to benefit years beginning prior to July 1,
14 1989, wages paid to an individual during his base period by a
15 governmental entity which elects to make payments in lieu of
16 contributions for less than full time work, performed during
17 the same weeks in the base period during which the individual
18 had other insured work, shall not be subject to payments in
19 lieu of contribution (upon such employer's request pursuant to
20 the regulation of the Director) so long as the employer
21 continued after the end of the base period, and continues
22 during the applicable benefit year, to furnish such less than
23 full time work to the individual on the same basis and in
24 substantially the same amount as during the base period. If the
25 individual is paid benefits with respect to a week (in the
26 applicable benefit year) after the employer has ceased to

1 furnish the work hereinabove described, the governmental
2 entity shall be liable for payments in lieu of contributions
3 with respect to the benefits paid to the individual after the
4 date on which the governmental entity ceases to furnish the
5 work.

6 7. An Indian tribe may elect to make payments in lieu of
7 contributions for calendar year 2003, provided that it files
8 its written election with the Director not later than January
9 31, 2003, and provided further that it is not delinquent in the
10 payment of any contributions, interest, or penalties.

11 8. Failure of an Indian tribe to make a payment in lieu of
12 contributions, or a payment of interest or penalties due under
13 this Act, within 90 days after the Department serves notice of
14 the finality of a determination and assessment shall cause the
15 Indian tribe to lose the option of making payments in lieu of
16 contributions, effective as of the calendar year immediately
17 following the date on which the Department serves the notice.
18 Notice of the loss of the option to make payments in lieu of
19 contributions may be protested in the same manner as a
20 determination and assessment under Section 2200 of this Act.

21 9. An Indian tribe that, pursuant to paragraph 8, loses the
22 option of making payments in lieu of contributions may again
23 elect to make payments in lieu of contributions for a calendar
24 year if: (a) the Indian tribe has incurred liability for the
25 payment of contributions for at least one calendar year since
26 losing the option pursuant to paragraph 8, (b) the Indian tribe

1 is not delinquent in the payment of any liabilities under the
2 Act, including interest or penalties, and (c) the Indian tribe
3 files its written election with the Director not later than
4 January 31 of the year with respect to which it is making the
5 election.

6 C. As soon as practicable following the close of each
7 calendar quarter, the Director shall mail to each governmental
8 entity which has elected to make payments in lieu of
9 contributions a Statement of the amount due from it for all the
10 regular and extended benefits paid during the calendar quarter,
11 together with the names of its workers or former workers and
12 the amounts of benefits paid to each of them during the
13 calendar quarter with respect to benefit years beginning prior
14 to July 1, 1989, on the basis of wages for insured work paid to
15 them by the governmental entity; or, with respect to benefit
16 years beginning after June 30, 1989, if such governmental
17 entity was the last employer as provided in Section 1502.1 with
18 respect to a benefit year beginning during the effective period
19 of the election. All of the provisions of subsection B of
20 Section 1404 pertaining to nonprofit organizations, not
21 inconsistent with the preceding sentence, shall be applicable
22 to payments in lieu of contributions by a governmental entity.

23 D. The provisions of subsections C through F, inclusive, of
24 Section 1404, pertaining to nonprofit organizations, shall be
25 applicable to each governmental entity which has elected to
26 make payments in lieu of contributions.

1 E. 1. If an Indian tribe fails to pay any liability under
2 this Act (including assessments of interest or penalty) within
3 90 days after the Department issues a notice of the finality of
4 a determination and assessment, the Director shall immediately
5 notify the United States Internal Revenue Service and the
6 United States Department of Labor.

7 2. Notices of payment and reporting delinquencies to Indian
8 tribes shall include information that failure to make full
9 payment within the prescribed time frame:

10 a. will cause the Indian tribe to lose the exemption
11 provided by Section 3306(c)(7) of the Federal Unemployment
12 Tax Act with respect to the federal unemployment tax;

13 b. will cause the Indian tribe to lose the option to
14 make payments in lieu of contributions.

15 (Source: P.A. 92-555, eff. 6-24-02.)

16 (820 ILCS 405/1801.1)

17 Sec. 1801.1. Directory of New Hires.

18 A. The Director shall establish and operate an automated
19 directory of newly hired employees which shall be known as the
20 "Illinois Directory of New Hires" which shall contain the
21 information required to be reported by employers to the
22 Department under subsection B. In the administration of the
23 Directory, the Director shall comply with any requirements
24 concerning the Employer New Hire Reporting Program established
25 by the federal Personal Responsibility and Work Opportunity

1 Reconciliation Act of 1996. The Director is authorized to use
2 the information contained in the Directory of New Hires to
3 administer any of the provisions of this Act.

4 B. Each employer in Illinois, except a department, agency,
5 or instrumentality of the United States, shall file with the
6 Department a report in accordance with rules adopted by the
7 Department (but in any event not later than 20 days after the
8 date the employer hires the employee or, in the case of an
9 employer transmitting reports magnetically or electronically,
10 by 2 monthly transmissions, if necessary, not less than 12 days
11 nor more than 16 days apart) providing the following
12 information concerning each newly hired employee: the
13 employee's name, address, and social security number, the date
14 services for remuneration were first performed by the employee,
15 the employee's projected monthly wages, and the employer's
16 name, address, Federal Employer Identification Number assigned
17 under Section 6109 of the Internal Revenue Code of 1986, and
18 such other information as may be required by federal law or
19 regulation, provided that each employer may voluntarily file
20 the address to which the employer wants income withholding
21 orders to be mailed, if it is different from the address given
22 on the Federal Employer Identification Number. An employer in
23 Illinois which transmits its reports electronically or
24 magnetically and which also has employees in another state may
25 report all newly hired employees to a single designated state
26 in which the employer has employees if it has so notified the

1 Secretary of the United States Department of Health and Human
2 Services in writing. An employer may, at its option, submit
3 information regarding any rehired employee in the same manner
4 as information is submitted regarding a newly hired employee.
5 Each report required under this subsection shall, to the extent
6 practicable, be made on an Internal Revenue Service Form W-4
7 or, at the option of the employer, an equivalent form, and may
8 be transmitted by first class mail, by telefax, magnetically,
9 or electronically.

10 C. An employer which knowingly fails to comply with the
11 reporting requirements established by this Section shall be
12 subject to a civil penalty of \$15 for each individual whom it
13 fails to report. An employer shall be considered to have
14 knowingly failed to comply with the reporting requirements
15 established by this Section with respect to an individual if
16 the employer has been notified by the Department that it has
17 failed to report an individual, and it fails, without
18 reasonable cause, to supply the required information to the
19 Department within 21 days after the date of mailing of the
20 notice. Any individual who knowingly conspires with the newly
21 hired employee to cause the employer to fail to report the
22 information required by this Section or who knowingly conspires
23 with the newly hired employee to cause the employer to file a
24 false or incomplete report shall be guilty of a Class B
25 misdemeanor with a fine not to exceed \$500 with respect to each
26 employee with whom the individual so conspires.

1 D. As used in this Section, "newly hired employee" means an
2 individual who is an employee within the meaning of Chapter 24
3 of the Internal Revenue Code of 1986, and whose reporting to
4 work which results in earnings from the employer is the first
5 instance within the preceding 180 days that the individual has
6 reported for work for which earnings were received from that
7 employer; however, "newly hired employee" does not include an
8 employee of a federal or State agency performing intelligence
9 or counterintelligence functions, if the head of that agency
10 has determined that the filing of the report required by this
11 Section with respect to the employee could endanger the safety
12 of the employee or compromise an ongoing investigation or
13 intelligence mission.

14 Notwithstanding Section 205, and for the purposes of this
15 Section only, the term "employer" has the meaning given by
16 Section 3401(d) of the Internal Revenue Code of 1986 and
17 includes any governmental entity and labor organization as
18 defined by Section 2(5) of the National Labor Relations Act,
19 and includes any entity (also known as a hiring hall) which is
20 used by the organization and an employer to carry out the
21 requirements described in Section 8(f)(3) of that Act of an
22 agreement between the organization and the employer.

23 (Source: P.A. 97-621, eff. 11-18-11.)

24 (820 ILCS 405/1900) (from Ch. 48, par. 640)

25 Sec. 1900. Disclosure of information.

1 A. Except as provided in this Section, information obtained
2 from any individual or employing unit during the administration
3 of this Act shall:

4 1. be confidential,

5 2. not be published or open to public inspection,

6 3. not be used in any court in any pending action or
7 proceeding,

8 4. not be admissible in evidence in any action or
9 proceeding other than one arising out of this Act.

10 B. No finding, determination, decision, ruling or order
11 (including any finding of fact, statement or conclusion made
12 therein) issued pursuant to this Act shall be admissible or
13 used in evidence in any action other than one arising out of
14 this Act, nor shall it be binding or conclusive except as
15 provided in this Act, nor shall it constitute res judicata,
16 regardless of whether the actions were between the same or
17 related parties or involved the same facts.

18 C. Any officer or employee of this State, any officer or
19 employee of any entity authorized to obtain information
20 pursuant to this Section, and any agent of this State or of
21 such entity who, except with authority of the Director under
22 this Section, shall disclose information shall be guilty of a
23 Class B misdemeanor and shall be disqualified from holding any
24 appointment or employment by the State.

25 D. An individual or his duly authorized agent may be
26 supplied with information from records only to the extent

1 necessary for the proper presentation of his claim for benefits
2 or with his existing or prospective rights to benefits.
3 Discretion to disclose this information belongs solely to the
4 Director and is not subject to a release or waiver by the
5 individual. Notwithstanding any other provision to the
6 contrary, an individual or his or her duly authorized agent may
7 be supplied with a statement of the amount of benefits paid to
8 the individual during the 18 months preceding the date of his
9 or her request.

10 E. An employing unit may be furnished with information,
11 only if deemed by the Director as necessary to enable it to
12 fully discharge its obligations or safeguard its rights under
13 the Act. Discretion to disclose this information belongs solely
14 to the Director and is not subject to a release or waiver by
15 the employing unit.

16 F. The Director may furnish any information that he may
17 deem proper to any public officer or public agency of this or
18 any other State or of the federal government dealing with:

- 19 1. the administration of relief,
- 20 2. public assistance,
- 21 3. unemployment compensation,
- 22 4. a system of public employment offices,
- 23 5. wages and hours of employment, or
- 24 6. a public works program.

25 The Director may make available to the Illinois Workers'
26 Compensation Commission information regarding employers for

1 the purpose of verifying the insurance coverage required under
2 the Workers' Compensation Act and Workers' Occupational
3 Diseases Act.

4 G. The Director may disclose information submitted by the
5 State or any of its political subdivisions, municipal
6 corporations, instrumentalities, or school or community
7 college districts, except for information which specifically
8 identifies an individual claimant.

9 H. The Director shall disclose only that information
10 required to be disclosed under Section 303 of the Social
11 Security Act, as amended, including:

12 1. any information required to be given the United
13 States Department of Labor under Section 303(a)(6); and

14 2. the making available upon request to any agency of
15 the United States charged with the administration of public
16 works or assistance through public employment, the name,
17 address, ordinary occupation and employment status of each
18 recipient of unemployment compensation, and a statement of
19 such recipient's right to further compensation under such
20 law as required by Section 303(a)(7); and

21 3. records to make available to the Railroad Retirement
22 Board as required by Section 303(c)(1); and

23 4. information that will assure reasonable cooperation
24 with every agency of the United States charged with the
25 administration of any unemployment compensation law as
26 required by Section 303(c)(2); and

1 5. information upon request and on a reimbursable basis
2 to the United States Department of Agriculture and to any
3 State food stamp agency concerning any information
4 required to be furnished by Section 303(d); and

5 6. any wage information upon request and on a
6 reimbursable basis to any State or local child support
7 enforcement agency required by Section 303(e); and

8 7. any information required under the income
9 eligibility and verification system as required by Section
10 303(f); and

11 8. information that might be useful in locating an
12 absent parent or that parent's employer, establishing
13 paternity or establishing, modifying, or enforcing child
14 support orders for the purpose of a child support
15 enforcement program under Title IV of the Social Security
16 Act upon the request of and on a reimbursable basis to the
17 public agency administering the Federal Parent Locator
18 Service as required by Section 303(h); and

19 9. information, upon request, to representatives of
20 any federal, State or local governmental public housing
21 agency with respect to individuals who have signed the
22 appropriate consent form approved by the Secretary of
23 Housing and Urban Development and who are applying for or
24 participating in any housing assistance program
25 administered by the United States Department of Housing and
26 Urban Development as required by Section 303(i).

1 I. The Director, upon the request of a public agency of
2 Illinois, of the federal government or of any other state
3 charged with the investigation or enforcement of Section 10-5
4 of the Criminal Code of 1961 (or a similar federal law or
5 similar law of another State), may furnish the public agency
6 information regarding the individual specified in the request
7 as to:

8 1. the current or most recent home address of the
9 individual, and

10 2. the names and addresses of the individual's
11 employers.

12 J. Nothing in this Section shall be deemed to interfere
13 with the disclosure of certain records as provided for in
14 Section 1706 or with the right to make available to the
15 Internal Revenue Service of the United States Department of the
16 Treasury, or the Department of Revenue of the State of
17 Illinois, information obtained under this Act.

18 K. The Department shall make available to the Illinois
19 Student Assistance Commission, upon request, information in
20 the possession of the Department that may be necessary or
21 useful to the Commission in the collection of defaulted or
22 delinquent student loans which the Commission administers.

23 L. The Department shall make available to the State
24 Employees' Retirement System, the State Universities
25 Retirement System, the Teachers' Retirement System of the State
26 of Illinois, and the Department of Central Management Services,

1 Risk Management Division, upon request, information in the
2 possession of the Department that may be necessary or useful to
3 the System or the Risk Management Division for the purpose of
4 determining whether any recipient of a disability benefit from
5 the System or a workers' compensation benefit from the Risk
6 Management Division is gainfully employed.

7 M. This Section shall be applicable to the information
8 obtained in the administration of the State employment service,
9 except that the Director may publish or release general labor
10 market information and may furnish information that he may deem
11 proper to an individual, public officer or public agency of
12 this or any other State or the federal government (in addition
13 to those public officers or public agencies specified in this
14 Section) as he prescribes by Rule.

15 N. The Director may require such safeguards as he deems
16 proper to insure that information disclosed pursuant to this
17 Section is used only for the purposes set forth in this
18 Section.

19 O. Nothing in this Section prohibits communication with an
20 individual or entity through unencrypted e-mail or other
21 unencrypted electronic means as long as the communication does
22 not contain the individual's or entity's name in combination
23 with any one or more of the individual's or entity's social
24 security number; driver's license or State identification
25 number; account number or credit or debit card number; or any
26 required security code, access code, or password that would

1 permit access to further information pertaining to the
2 individual or entity.

3 P. Within 30 days after the effective date of this
4 amendatory Act of 1993 and annually thereafter, the Department
5 shall provide to the Department of Financial Institutions a
6 list of individuals or entities that, for the most recently
7 completed calendar year, report to the Department as paying
8 wages to workers. The lists shall be deemed confidential and
9 may not be disclosed to any other person.

10 Q. The Director shall make available to an elected federal
11 official the name and address of an individual or entity that
12 is located within the jurisdiction from which the official was
13 elected and that, for the most recently completed calendar
14 year, has reported to the Department as paying wages to
15 workers, where the information will be used in connection with
16 the official duties of the official and the official requests
17 the information in writing, specifying the purposes for which
18 it will be used. For purposes of this subsection, the use of
19 information in connection with the official duties of an
20 official does not include use of the information in connection
21 with the solicitation of contributions or expenditures, in
22 money or in kind, to or on behalf of a candidate for public or
23 political office or a political party or with respect to a
24 public question, as defined in Section 1-3 of the Election
25 Code, or in connection with any commercial solicitation. Any
26 elected federal official who, in submitting a request for

1 information covered by this subsection, knowingly makes a false
2 statement or fails to disclose a material fact, with the intent
3 to obtain the information for a purpose not authorized by this
4 subsection, shall be guilty of a Class B misdemeanor.

5 R. The Director may provide to any State or local child
6 support agency, upon request and on a reimbursable basis,
7 information that might be useful in locating an absent parent
8 or that parent's employer, establishing paternity, or
9 establishing, modifying, or enforcing child support orders.

10 S. The Department shall make available to a State's
11 Attorney of this State or a State's Attorney's investigator,
12 upon request, the current address or, if the current address is
13 unavailable, current employer information, if available, of a
14 victim of a felony or a witness to a felony or a person against
15 whom an arrest warrant is outstanding.

16 T. The Director shall make available to the Department of
17 State Police, a county sheriff's office, or a municipal police
18 department, upon request, any information concerning the
19 current address and place of employment or former places of
20 employment of a person who is required to register as a sex
21 offender under the Sex Offender Registration Act that may be
22 useful in enforcing the registration provisions of that Act.

23 U. The Director shall make information available to the
24 Department of Healthcare and Family Services and the Department
25 of Human Services for the purpose of determining eligibility
26 for public benefit programs authorized under the Illinois

1 Public Aid Code and related statutes administered by those
2 departments, for verifying sources and amounts of income, and
3 for other purposes directly connected with the administration
4 of those programs.

5 (Source: P.A. 96-420, eff. 8-13-09; 97-621, eff. 11-18-11.)

6 Section 905. The State Comptroller Act is amended by
7 changing Section 10.05 as follows:

8 (15 ILCS 405/10.05) (from Ch. 15, par. 210.05)

9 Sec. 10.05. Deductions from warrants; statement of reason
10 for deduction. Whenever any person shall be entitled to a
11 warrant or other payment from the treasury or other funds held
12 by the State Treasurer, on any account, against whom there
13 shall be any then due and payable account or claim in favor of
14 the State, the United States upon certification by the
15 Secretary of the Treasury of the United States, or his or her
16 delegate, pursuant to a reciprocal offset agreement under
17 subsection (i-1) of Section 10 of the Illinois State Collection
18 Act of 1986, or a unit of local government, a school district,
19 or a public institution of higher education, as defined in
20 Section 1 of the Board of Higher Education Act, upon
21 certification by that entity, the Comptroller, upon
22 notification thereof, shall ascertain the amount due and
23 payable to the State, the United States, the unit of local
24 government, the school district, or the public institution of

1 higher education, as aforesaid, and draw a warrant on the
2 treasury or on other funds held by the State Treasurer, stating
3 the amount for which the party was entitled to a warrant or
4 other payment, the amount deducted therefrom, and on what
5 account, and directing the payment of the balance; which
6 warrant or payment as so drawn shall be entered on the books of
7 the Treasurer, and such balance only shall be paid. The
8 Comptroller may deduct any one or more of the following: (i)
9 the entire amount due and payable to the State or a portion of
10 the amount due and payable to the State in accordance with the
11 request of the notifying agency; (ii) the entire amount due and
12 payable to the United States or a portion of the amount due and
13 payable to the United States in accordance with a reciprocal
14 offset agreement under subsection (i-1) of Section 10 of the
15 Illinois State Collection Act of 1986; or (iii) the entire
16 amount due and payable to the unit of local government, school
17 district, or public institution of higher education or a
18 portion of the amount due and payable to that entity in
19 accordance with an intergovernmental agreement authorized
20 under this Section and Section 10.05d. No request from a
21 notifying agency, the Secretary of the Treasury of the United
22 States, a unit of local government, a school district, or a
23 public institution of higher education for an amount to be
24 deducted under this Section from a wage or salary payment, or
25 from a contractual payment to an individual for personal
26 services, shall exceed 25% of the net amount of such payment.

1 "Net amount" means that part of the earnings of an individual
2 remaining after deduction of any amounts required by law to be
3 withheld. For purposes of this provision, wage, salary or other
4 payments for personal services shall not include final
5 compensation payments for the value of accrued vacation,
6 overtime or sick leave. Whenever the Comptroller draws a
7 warrant or makes a payment involving a deduction ordered under
8 this Section, the Comptroller shall notify the payee and the
9 State agency that submitted the voucher of the reason for the
10 deduction and he or she shall retain a record of such statement
11 in his or her records. As used in this Section, an "account or
12 claim in favor of the State" includes all amounts owing to
13 "State agencies" as defined in Section 7 of this Act. However,
14 the Comptroller shall not be required to accept accounts or
15 claims owing to funds not held by the State Treasurer, where
16 such accounts or claims do not exceed \$50, nor shall the
17 Comptroller deduct from funds held by the State Treasurer under
18 the Senior Citizens and Disabled Persons Property Tax Relief
19 ~~and Pharmaceutical Assistance~~ Act or for payments to
20 institutions from the Illinois Prepaid Tuition Trust Fund
21 (unless the Trust Fund moneys are used for child support). The
22 Comptroller and the Department of Revenue shall enter into an
23 interagency agreement to establish responsibilities, duties,
24 and procedures relating to deductions from lottery prizes
25 awarded under Section 20.1 of the Illinois Lottery Law. The
26 Comptroller may enter into an intergovernmental agreement with

1 the Department of Revenue and the Secretary of the Treasury of
2 the United States, or his or her delegate, to establish
3 responsibilities, duties, and procedures relating to
4 reciprocal offset of delinquent State and federal obligations
5 pursuant to subsection (i-1) of Section 10 of the Illinois
6 State Collection Act of 1986. The Comptroller may enter into
7 intergovernmental agreements with any unit of local
8 government, school district, or public institution of higher
9 education to establish responsibilities, duties, and
10 procedures to provide for the offset, by the Comptroller, of
11 obligations owed to those entities.

12 (Source: P.A. 97-269, eff. 12-16-11 (see Section 15 of P.A.
13 97-632 for the effective date of changes made by P.A. 97-269);
14 97-632, eff. 12-16-11.)

15 Section 910. The State Finance Act is amended by changing
16 Section 6z-81 as follows:

17 (30 ILCS 105/6z-81)

18 Sec. 6z-81. Healthcare Provider Relief Fund.

19 (a) There is created in the State treasury a special fund
20 to be known as the Healthcare Provider Relief Fund.

21 (b) The Fund is created for the purpose of receiving and
22 disbursing moneys in accordance with this Section.
23 Disbursements from the Fund shall be made only as follows:

24 (1) Subject to appropriation, for payment by the

1 Department of Healthcare and Family Services or by the
2 Department of Human Services of medical bills and related
3 expenses, including administrative expenses, for which the
4 State is responsible under Titles XIX and XXI of the Social
5 Security Act, the Illinois Public Aid Code, the Children's
6 Health Insurance Program Act, the Covering ALL KIDS Health
7 Insurance Act, and the Long Term Acute Care Hospital
8 Quality Improvement Transfer Program Act. ~~, and the Senior~~
9 ~~Citizens and Disabled Persons Property Tax Relief and~~
10 ~~Pharmaceutical Assistance Act.~~

11 (2) For repayment of funds borrowed from other State
12 funds or from outside sources, including interest thereon.

13 (c) The Fund shall consist of the following:

14 (1) Moneys received by the State from short-term
15 borrowing pursuant to the Short Term Borrowing Act on or
16 after the effective date of this amendatory Act of the 96th
17 General Assembly.

18 (2) All federal matching funds received by the Illinois
19 Department of Healthcare and Family Services as a result of
20 expenditures made by the Department that are attributable
21 to moneys deposited in the Fund.

22 (3) All federal matching funds received by the Illinois
23 Department of Healthcare and Family Services as a result of
24 federal approval of Title XIX State plan amendment
25 transmittal number 07-09.

26 (4) All other moneys received for the Fund from any

1 other source, including interest earned thereon.

2 (d) In addition to any other transfers that may be provided
3 for by law, on the effective date of this amendatory Act of the
4 97th General Assembly, or as soon thereafter as practical, the
5 State Comptroller shall direct and the State Treasurer shall
6 transfer the sum of \$365,000,000 from the General Revenue Fund
7 into the Healthcare Provider Relief Fund.

8 (e) In addition to any other transfers that may be provided
9 for by law, on July 1, 2011, or as soon thereafter as
10 practical, the State Comptroller shall direct and the State
11 Treasurer shall transfer the sum of \$160,000,000 from the
12 General Revenue Fund to the Healthcare Provider Relief Fund.

13 (Source: P.A. 96-820, eff. 11-18-09; 96-1100, eff. 1-1-11;
14 97-44, eff. 6-28-11; 97-641, eff. 12-19-11.)

15 Section 915. The Downstate Public Transportation Act is
16 amended by changing Sections 2-15.2 and 2-15.3 as follows:

17 (30 ILCS 740/2-15.2)

18 Sec. 2-15.2. Free services; eligibility.

19 (a) Notwithstanding any law to the contrary, no later than
20 60 days following the effective date of this amendatory Act of
21 the 95th General Assembly and until subsection (b) is
22 implemented, any fixed route public transportation services
23 provided by, or under grant or purchase of service contracts
24 of, every participant, as defined in Section 2-2.02 (1)(a),

1 shall be provided without charge to all senior citizen
2 residents of the participant aged 65 and older, under such
3 conditions as shall be prescribed by the participant.

4 (b) Notwithstanding any law to the contrary, no later than
5 180 days following the effective date of this amendatory Act of
6 the 96th General Assembly, any fixed route public
7 transportation services provided by, or under grant or purchase
8 of service contracts of, every participant, as defined in
9 Section 2-2.02 (1)(a), shall be provided without charge to
10 senior citizens aged 65 and older who meet the income
11 eligibility limitation set forth in subsection (a-5) of Section
12 4 of the Senior Citizens and Disabled Persons Property Tax
13 Relief ~~and Pharmaceutical Assistance~~ Act, under such
14 conditions as shall be prescribed by the participant. The
15 Department on Aging shall furnish all information reasonably
16 necessary to determine eligibility, including updated lists of
17 individuals who are eligible for services without charge under
18 this Section. Nothing in this Section shall relieve the
19 participant from providing reduced fares as may be required by
20 federal law.

21 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

22 (30 ILCS 740/2-15.3)

23 Sec. 2-15.3. Transit services for disabled individuals.
24 Notwithstanding any law to the contrary, no later than 60 days
25 following the effective date of this amendatory Act of the 95th

1 General Assembly, all fixed route public transportation
2 services provided by, or under grant or purchase of service
3 contract of, any participant shall be provided without charge
4 to all disabled persons who meet the income eligibility
5 limitation set forth in subsection (a-5) of Section 4 of the
6 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
7 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
8 be prescribed by the participant. The Department on Aging shall
9 furnish all information reasonably necessary to determine
10 eligibility, including updated lists of individuals who are
11 eligible for services without charge under this Section.

12 (Source: P.A. 95-906, eff. 8-26-08.)

13 Section 920. The Property Tax Code is amended by changing
14 Sections 15-172, 15-175, 20-15, and 21-27 as follows:

15 (35 ILCS 200/15-172)

16 Sec. 15-172. Senior Citizens Assessment Freeze Homestead
17 Exemption.

18 (a) This Section may be cited as the Senior Citizens
19 Assessment Freeze Homestead Exemption.

20 (b) As used in this Section:

21 "Applicant" means an individual who has filed an
22 application under this Section.

23 "Base amount" means the base year equalized assessed value
24 of the residence plus the first year's equalized assessed value

1 of any added improvements which increased the assessed value of
2 the residence after the base year.

3 "Base year" means the taxable year prior to the taxable
4 year for which the applicant first qualifies and applies for
5 the exemption provided that in the prior taxable year the
6 property was improved with a permanent structure that was
7 occupied as a residence by the applicant who was liable for
8 paying real property taxes on the property and who was either
9 (i) an owner of record of the property or had legal or
10 equitable interest in the property as evidenced by a written
11 instrument or (ii) had a legal or equitable interest as a
12 lessee in the parcel of property that was single family
13 residence. If in any subsequent taxable year for which the
14 applicant applies and qualifies for the exemption the equalized
15 assessed value of the residence is less than the equalized
16 assessed value in the existing base year (provided that such
17 equalized assessed value is not based on an assessed value that
18 results from a temporary irregularity in the property that
19 reduces the assessed value for one or more taxable years), then
20 that subsequent taxable year shall become the base year until a
21 new base year is established under the terms of this paragraph.
22 For taxable year 1999 only, the Chief County Assessment Officer
23 shall review (i) all taxable years for which the applicant
24 applied and qualified for the exemption and (ii) the existing
25 base year. The assessment officer shall select as the new base
26 year the year with the lowest equalized assessed value. An

1 equalized assessed value that is based on an assessed value
2 that results from a temporary irregularity in the property that
3 reduces the assessed value for one or more taxable years shall
4 not be considered the lowest equalized assessed value. The
5 selected year shall be the base year for taxable year 1999 and
6 thereafter until a new base year is established under the terms
7 of this paragraph.

8 "Chief County Assessment Officer" means the County
9 Assessor or Supervisor of Assessments of the county in which
10 the property is located.

11 "Equalized assessed value" means the assessed value as
12 equalized by the Illinois Department of Revenue.

13 "Household" means the applicant, the spouse of the
14 applicant, and all persons using the residence of the applicant
15 as their principal place of residence.

16 "Household income" means the combined income of the members
17 of a household for the calendar year preceding the taxable
18 year.

19 "Income" has the same meaning as provided in Section 3.07
20 of the Senior Citizens and Disabled Persons Property Tax Relief
21 ~~and Pharmaceutical Assistance~~ Act, except that, beginning in
22 assessment year 2001, "income" does not include veteran's
23 benefits.

24 "Internal Revenue Code of 1986" means the United States
25 Internal Revenue Code of 1986 or any successor law or laws
26 relating to federal income taxes in effect for the year

1 preceding the taxable year.

2 "Life care facility that qualifies as a cooperative" means
3 a facility as defined in Section 2 of the Life Care Facilities
4 Act.

5 "Maximum income limitation" means:

6 (1) \$35,000 prior to taxable year 1999;

7 (2) \$40,000 in taxable years 1999 through 2003;

8 (3) \$45,000 in taxable years 2004 through 2005;

9 (4) \$50,000 in taxable years 2006 and 2007; and

10 (5) \$55,000 in taxable year 2008 and thereafter.

11 "Residence" means the principal dwelling place and
12 appurtenant structures used for residential purposes in this
13 State occupied on January 1 of the taxable year by a household
14 and so much of the surrounding land, constituting the parcel
15 upon which the dwelling place is situated, as is used for
16 residential purposes. If the Chief County Assessment Officer
17 has established a specific legal description for a portion of
18 property constituting the residence, then that portion of
19 property shall be deemed the residence for the purposes of this
20 Section.

21 "Taxable year" means the calendar year during which ad
22 valorem property taxes payable in the next succeeding year are
23 levied.

24 (c) Beginning in taxable year 1994, a senior citizens
25 assessment freeze homestead exemption is granted for real
26 property that is improved with a permanent structure that is

1 occupied as a residence by an applicant who (i) is 65 years of
2 age or older during the taxable year, (ii) has a household
3 income that does not exceed the maximum income limitation,
4 (iii) is liable for paying real property taxes on the property,
5 and (iv) is an owner of record of the property or has a legal or
6 equitable interest in the property as evidenced by a written
7 instrument. This homestead exemption shall also apply to a
8 leasehold interest in a parcel of property improved with a
9 permanent structure that is a single family residence that is
10 occupied as a residence by a person who (i) is 65 years of age
11 or older during the taxable year, (ii) has a household income
12 that does not exceed the maximum income limitation, (iii) has a
13 legal or equitable ownership interest in the property as
14 lessee, and (iv) is liable for the payment of real property
15 taxes on that property.

16 In counties of 3,000,000 or more inhabitants, the amount of
17 the exemption for all taxable years is the equalized assessed
18 value of the residence in the taxable year for which
19 application is made minus the base amount. In all other
20 counties, the amount of the exemption is as follows: (i)
21 through taxable year 2005 and for taxable year 2007 and
22 thereafter, the amount of this exemption shall be the equalized
23 assessed value of the residence in the taxable year for which
24 application is made minus the base amount; and (ii) for taxable
25 year 2006, the amount of the exemption is as follows:

26 (1) For an applicant who has a household income of

1 \$45,000 or less, the amount of the exemption is the
2 equalized assessed value of the residence in the taxable
3 year for which application is made minus the base amount.

4 (2) For an applicant who has a household income
5 exceeding \$45,000 but not exceeding \$46,250, the amount of
6 the exemption is (i) the equalized assessed value of the
7 residence in the taxable year for which application is made
8 minus the base amount (ii) multiplied by 0.8.

9 (3) For an applicant who has a household income
10 exceeding \$46,250 but not exceeding \$47,500, the amount of
11 the exemption is (i) the equalized assessed value of the
12 residence in the taxable year for which application is made
13 minus the base amount (ii) multiplied by 0.6.

14 (4) For an applicant who has a household income
15 exceeding \$47,500 but not exceeding \$48,750, the amount of
16 the exemption is (i) the equalized assessed value of the
17 residence in the taxable year for which application is made
18 minus the base amount (ii) multiplied by 0.4.

19 (5) For an applicant who has a household income
20 exceeding \$48,750 but not exceeding \$50,000, the amount of
21 the exemption is (i) the equalized assessed value of the
22 residence in the taxable year for which application is made
23 minus the base amount (ii) multiplied by 0.2.

24 When the applicant is a surviving spouse of an applicant
25 for a prior year for the same residence for which an exemption
26 under this Section has been granted, the base year and base

1 amount for that residence are the same as for the applicant for
2 the prior year.

3 Each year at the time the assessment books are certified to
4 the County Clerk, the Board of Review or Board of Appeals shall
5 give to the County Clerk a list of the assessed values of
6 improvements on each parcel qualifying for this exemption that
7 were added after the base year for this parcel and that
8 increased the assessed value of the property.

9 In the case of land improved with an apartment building
10 owned and operated as a cooperative or a building that is a
11 life care facility that qualifies as a cooperative, the maximum
12 reduction from the equalized assessed value of the property is
13 limited to the sum of the reductions calculated for each unit
14 occupied as a residence by a person or persons (i) 65 years of
15 age or older, (ii) with a household income that does not exceed
16 the maximum income limitation, (iii) who is liable, by contract
17 with the owner or owners of record, for paying real property
18 taxes on the property, and (iv) who is an owner of record of a
19 legal or equitable interest in the cooperative apartment
20 building, other than a leasehold interest. In the instance of a
21 cooperative where a homestead exemption has been granted under
22 this Section, the cooperative association or its management
23 firm shall credit the savings resulting from that exemption
24 only to the apportioned tax liability of the owner who
25 qualified for the exemption. Any person who willfully refuses
26 to credit that savings to an owner who qualifies for the

1 exemption is guilty of a Class B misdemeanor.

2 When a homestead exemption has been granted under this
3 Section and an applicant then becomes a resident of a facility
4 licensed under the Assisted Living and Shared Housing Act, the
5 Nursing Home Care Act, the Specialized Mental Health
6 Rehabilitation Act, or the ID/DD Community Care Act, the
7 exemption shall be granted in subsequent years so long as the
8 residence (i) continues to be occupied by the qualified
9 applicant's spouse or (ii) if remaining unoccupied, is still
10 owned by the qualified applicant for the homestead exemption.

11 Beginning January 1, 1997, when an individual dies who
12 would have qualified for an exemption under this Section, and
13 the surviving spouse does not independently qualify for this
14 exemption because of age, the exemption under this Section
15 shall be granted to the surviving spouse for the taxable year
16 preceding and the taxable year of the death, provided that,
17 except for age, the surviving spouse meets all other
18 qualifications for the granting of this exemption for those
19 years.

20 When married persons maintain separate residences, the
21 exemption provided for in this Section may be claimed by only
22 one of such persons and for only one residence.

23 For taxable year 1994 only, in counties having less than
24 3,000,000 inhabitants, to receive the exemption, a person shall
25 submit an application by February 15, 1995 to the Chief County
26 Assessment Officer of the county in which the property is

1 located. In counties having 3,000,000 or more inhabitants, for
2 taxable year 1994 and all subsequent taxable years, to receive
3 the exemption, a person may submit an application to the Chief
4 County Assessment Officer of the county in which the property
5 is located during such period as may be specified by the Chief
6 County Assessment Officer. The Chief County Assessment Officer
7 in counties of 3,000,000 or more inhabitants shall annually
8 give notice of the application period by mail or by
9 publication. In counties having less than 3,000,000
10 inhabitants, beginning with taxable year 1995 and thereafter,
11 to receive the exemption, a person shall submit an application
12 by July 1 of each taxable year to the Chief County Assessment
13 Officer of the county in which the property is located. A
14 county may, by ordinance, establish a date for submission of
15 applications that is different than July 1. The applicant shall
16 submit with the application an affidavit of the applicant's
17 total household income, age, marital status (and if married the
18 name and address of the applicant's spouse, if known), and
19 principal dwelling place of members of the household on January
20 1 of the taxable year. The Department shall establish, by rule,
21 a method for verifying the accuracy of affidavits filed by
22 applicants under this Section, and the Chief County Assessment
23 Officer may conduct audits of any taxpayer claiming an
24 exemption under this Section to verify that the taxpayer is
25 eligible to receive the exemption. Each application shall
26 contain or be verified by a written declaration that it is made

1 under the penalties of perjury. A taxpayer's signing a
2 fraudulent application under this Act is perjury, as defined in
3 Section 32-2 of the Criminal Code of 1961. The applications
4 shall be clearly marked as applications for the Senior Citizens
5 Assessment Freeze Homestead Exemption and must contain a notice
6 that any taxpayer who receives the exemption is subject to an
7 audit by the Chief County Assessment Officer.

8 Notwithstanding any other provision to the contrary, in
9 counties having fewer than 3,000,000 inhabitants, if an
10 applicant fails to file the application required by this
11 Section in a timely manner and this failure to file is due to a
12 mental or physical condition sufficiently severe so as to
13 render the applicant incapable of filing the application in a
14 timely manner, the Chief County Assessment Officer may extend
15 the filing deadline for a period of 30 days after the applicant
16 regains the capability to file the application, but in no case
17 may the filing deadline be extended beyond 3 months of the
18 original filing deadline. In order to receive the extension
19 provided in this paragraph, the applicant shall provide the
20 Chief County Assessment Officer with a signed statement from
21 the applicant's physician stating the nature and extent of the
22 condition, that, in the physician's opinion, the condition was
23 so severe that it rendered the applicant incapable of filing
24 the application in a timely manner, and the date on which the
25 applicant regained the capability to file the application.

26 Beginning January 1, 1998, notwithstanding any other

1 provision to the contrary, in counties having fewer than
2 3,000,000 inhabitants, if an applicant fails to file the
3 application required by this Section in a timely manner and
4 this failure to file is due to a mental or physical condition
5 sufficiently severe so as to render the applicant incapable of
6 filing the application in a timely manner, the Chief County
7 Assessment Officer may extend the filing deadline for a period
8 of 3 months. In order to receive the extension provided in this
9 paragraph, the applicant shall provide the Chief County
10 Assessment Officer with a signed statement from the applicant's
11 physician stating the nature and extent of the condition, and
12 that, in the physician's opinion, the condition was so severe
13 that it rendered the applicant incapable of filing the
14 application in a timely manner.

15 In counties having less than 3,000,000 inhabitants, if an
16 applicant was denied an exemption in taxable year 1994 and the
17 denial occurred due to an error on the part of an assessment
18 official, or his or her agent or employee, then beginning in
19 taxable year 1997 the applicant's base year, for purposes of
20 determining the amount of the exemption, shall be 1993 rather
21 than 1994. In addition, in taxable year 1997, the applicant's
22 exemption shall also include an amount equal to (i) the amount
23 of any exemption denied to the applicant in taxable year 1995
24 as a result of using 1994, rather than 1993, as the base year,
25 (ii) the amount of any exemption denied to the applicant in
26 taxable year 1996 as a result of using 1994, rather than 1993,

1 as the base year, and (iii) the amount of the exemption
2 erroneously denied for taxable year 1994.

3 For purposes of this Section, a person who will be 65 years
4 of age during the current taxable year shall be eligible to
5 apply for the homestead exemption during that taxable year.
6 Application shall be made during the application period in
7 effect for the county of his or her residence.

8 The Chief County Assessment Officer may determine the
9 eligibility of a life care facility that qualifies as a
10 cooperative to receive the benefits provided by this Section by
11 use of an affidavit, application, visual inspection,
12 questionnaire, or other reasonable method in order to insure
13 that the tax savings resulting from the exemption are credited
14 by the management firm to the apportioned tax liability of each
15 qualifying resident. The Chief County Assessment Officer may
16 request reasonable proof that the management firm has so
17 credited that exemption.

18 Except as provided in this Section, all information
19 received by the chief county assessment officer or the
20 Department from applications filed under this Section, or from
21 any investigation conducted under the provisions of this
22 Section, shall be confidential, except for official purposes or
23 pursuant to official procedures for collection of any State or
24 local tax or enforcement of any civil or criminal penalty or
25 sanction imposed by this Act or by any statute or ordinance
26 imposing a State or local tax. Any person who divulges any such

1 information in any manner, except in accordance with a proper
2 judicial order, is guilty of a Class A misdemeanor.

3 Nothing contained in this Section shall prevent the
4 Director or chief county assessment officer from publishing or
5 making available reasonable statistics concerning the
6 operation of the exemption contained in this Section in which
7 the contents of claims are grouped into aggregates in such a
8 way that information contained in any individual claim shall
9 not be disclosed.

10 (d) Each Chief County Assessment Officer shall annually
11 publish a notice of availability of the exemption provided
12 under this Section. The notice shall be published at least 60
13 days but no more than 75 days prior to the date on which the
14 application must be submitted to the Chief County Assessment
15 Officer of the county in which the property is located. The
16 notice shall appear in a newspaper of general circulation in
17 the county.

18 Notwithstanding Sections 6 and 8 of the State Mandates Act,
19 no reimbursement by the State is required for the
20 implementation of any mandate created by this Section.

21 (Source: P.A. 96-339, eff. 7-1-10; 96-355, eff. 1-1-10;
22 96-1000, eff. 7-2-10; 97-38, eff. 6-28-11; 97-227, eff. 1-1-12;
23 revised 9-12-11.)

24 (35 ILCS 200/15-175)

25 Sec. 15-175. General homestead exemption. Except as

1 provided in Sections 15-176 and 15-177, homestead property is
2 entitled to an annual homestead exemption limited, except as
3 described here with relation to cooperatives, to a reduction in
4 the equalized assessed value of homestead property equal to the
5 increase in equalized assessed value for the current assessment
6 year above the equalized assessed value of the property for
7 1977, up to the maximum reduction set forth below. If however,
8 the 1977 equalized assessed value upon which taxes were paid is
9 subsequently determined by local assessing officials, the
10 Property Tax Appeal Board, or a court to have been excessive,
11 the equalized assessed value which should have been placed on
12 the property for 1977 shall be used to determine the amount of
13 the exemption.

14 Except as provided in Section 15-176, the maximum reduction
15 before taxable year 2004 shall be \$4,500 in counties with
16 3,000,000 or more inhabitants and \$3,500 in all other counties.
17 Except as provided in Sections 15-176 and 15-177, for taxable
18 years 2004 through 2007, the maximum reduction shall be \$5,000,
19 for taxable year 2008, the maximum reduction is \$5,500, and,
20 for taxable years 2009 and thereafter, the maximum reduction is
21 \$6,000 in all counties. If a county has elected to subject
22 itself to the provisions of Section 15-176 as provided in
23 subsection (k) of that Section, then, for the first taxable
24 year only after the provisions of Section 15-176 no longer
25 apply, for owners who, for the taxable year, have not been
26 granted a senior citizens assessment freeze homestead

1 exemption under Section 15-172 or a long-time occupant
2 homestead exemption under Section 15-177, there shall be an
3 additional exemption of \$5,000 for owners with a household
4 income of \$30,000 or less.

5 In counties with fewer than 3,000,000 inhabitants, if,
6 based on the most recent assessment, the equalized assessed
7 value of the homestead property for the current assessment year
8 is greater than the equalized assessed value of the property
9 for 1977, the owner of the property shall automatically receive
10 the exemption granted under this Section in an amount equal to
11 the increase over the 1977 assessment up to the maximum
12 reduction set forth in this Section.

13 If in any assessment year beginning with the 2000
14 assessment year, homestead property has a pro-rata valuation
15 under Section 9-180 resulting in an increase in the assessed
16 valuation, a reduction in equalized assessed valuation equal to
17 the increase in equalized assessed value of the property for
18 the year of the pro-rata valuation above the equalized assessed
19 value of the property for 1977 shall be applied to the property
20 on a proportionate basis for the period the property qualified
21 as homestead property during the assessment year. The maximum
22 proportionate homestead exemption shall not exceed the maximum
23 homestead exemption allowed in the county under this Section
24 divided by 365 and multiplied by the number of days the
25 property qualified as homestead property.

26 "Homestead property" under this Section includes

1 residential property that is occupied by its owner or owners as
2 his or their principal dwelling place, or that is a leasehold
3 interest on which a single family residence is situated, which
4 is occupied as a residence by a person who has an ownership
5 interest therein, legal or equitable or as a lessee, and on
6 which the person is liable for the payment of property taxes.
7 For land improved with an apartment building owned and operated
8 as a cooperative or a building which is a life care facility as
9 defined in Section 15-170 and considered to be a cooperative
10 under Section 15-170, the maximum reduction from the equalized
11 assessed value shall be limited to the increase in the value
12 above the equalized assessed value of the property for 1977, up
13 to the maximum reduction set forth above, multiplied by the
14 number of apartments or units occupied by a person or persons
15 who is liable, by contract with the owner or owners of record,
16 for paying property taxes on the property and is an owner of
17 record of a legal or equitable interest in the cooperative
18 apartment building, other than a leasehold interest. For
19 purposes of this Section, the term "life care facility" has the
20 meaning stated in Section 15-170.

21 "Household", as used in this Section, means the owner, the
22 spouse of the owner, and all persons using the residence of the
23 owner as their principal place of residence.

24 "Household income", as used in this Section, means the
25 combined income of the members of a household for the calendar
26 year preceding the taxable year.

1 "Income", as used in this Section, has the same meaning as
2 provided in Section 3.07 of the Senior Citizens and Disabled
3 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act,
4 except that "income" does not include veteran's benefits.

5 In a cooperative where a homestead exemption has been
6 granted, the cooperative association or its management firm
7 shall credit the savings resulting from that exemption only to
8 the apportioned tax liability of the owner who qualified for
9 the exemption. Any person who willfully refuses to so credit
10 the savings shall be guilty of a Class B misdemeanor.

11 Where married persons maintain and reside in separate
12 residences qualifying as homestead property, each residence
13 shall receive 50% of the total reduction in equalized assessed
14 valuation provided by this Section.

15 In all counties, the assessor or chief county assessment
16 officer may determine the eligibility of residential property
17 to receive the homestead exemption and the amount of the
18 exemption by application, visual inspection, questionnaire or
19 other reasonable methods. The determination shall be made in
20 accordance with guidelines established by the Department,
21 provided that the taxpayer applying for an additional general
22 exemption under this Section shall submit to the chief county
23 assessment officer an application with an affidavit of the
24 applicant's total household income, age, marital status (and,
25 if married, the name and address of the applicant's spouse, if
26 known), and principal dwelling place of members of the

1 household on January 1 of the taxable year. The Department
2 shall issue guidelines establishing a method for verifying the
3 accuracy of the affidavits filed by applicants under this
4 paragraph. The applications shall be clearly marked as
5 applications for the Additional General Homestead Exemption.

6 In counties with fewer than 3,000,000 inhabitants, in the
7 event of a sale of homestead property the homestead exemption
8 shall remain in effect for the remainder of the assessment year
9 of the sale. The assessor or chief county assessment officer
10 may require the new owner of the property to apply for the
11 homestead exemption for the following assessment year.

12 Notwithstanding Sections 6 and 8 of the State Mandates Act,
13 no reimbursement by the State is required for the
14 implementation of any mandate created by this Section.

15 (Source: P.A. 95-644, eff. 10-12-07.)

16 (35 ILCS 200/20-15)

17 Sec. 20-15. Information on bill or separate statement.
18 There shall be printed on each bill, or on a separate slip
19 which shall be mailed with the bill:

20 (a) a statement itemizing the rate at which taxes have
21 been extended for each of the taxing districts in the
22 county in whose district the property is located, and in
23 those counties utilizing electronic data processing
24 equipment the dollar amount of tax due from the person
25 assessed allocable to each of those taxing districts,

1 including a separate statement of the dollar amount of tax
2 due which is allocable to a tax levied under the Illinois
3 Local Library Act or to any other tax levied by a
4 municipality or township for public library purposes,

5 (b) a separate statement for each of the taxing
6 districts of the dollar amount of tax due which is
7 allocable to a tax levied under the Illinois Pension Code
8 or to any other tax levied by a municipality or township
9 for public pension or retirement purposes,

10 (c) the total tax rate,

11 (d) the total amount of tax due, and

12 (e) the amount by which the total tax and the tax
13 allocable to each taxing district differs from the
14 taxpayer's last prior tax bill.

15 The county treasurer shall ensure that only those taxing
16 districts in which a parcel of property is located shall be
17 listed on the bill for that property.

18 In all counties the statement shall also provide:

19 (1) the property index number or other suitable
20 description,

21 (2) the assessment of the property,

22 (3) the equalization factors imposed by the county and
23 by the Department, and

24 (4) the equalized assessment resulting from the
25 application of the equalization factors to the basic
26 assessment.

1 In all counties which do not classify property for purposes
2 of taxation, for property on which a single family residence is
3 situated the statement shall also include a statement to
4 reflect the fair cash value determined for the property. In all
5 counties which classify property for purposes of taxation in
6 accordance with Section 4 of Article IX of the Illinois
7 Constitution, for parcels of residential property in the lowest
8 assessment classification the statement shall also include a
9 statement to reflect the fair cash value determined for the
10 property.

11 In all counties, the statement must include information
12 that certain taxpayers may be eligible for tax exemptions,
13 abatements, and other assistance programs and that, for more
14 information, taxpayers should consult with the office of their
15 township or county assessor and with the Illinois Department of
16 Revenue.

17 In all counties, the statement shall include information
18 that certain taxpayers may be eligible for the Senior Citizens
19 and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
20 ~~Assistance~~ Act and that applications are available from the
21 Illinois Department on Aging.

22 In counties which use the estimated or accelerated billing
23 methods, these statements shall only be provided with the final
24 installment of taxes due. The provisions of this Section create
25 a mandatory statutory duty. They are not merely directory or
26 discretionary. The failure or neglect of the collector to mail

1 the bill, or the failure of the taxpayer to receive the bill,
2 shall not affect the validity of any tax, or the liability for
3 the payment of any tax.

4 (Source: P.A. 95-644, eff. 10-12-07.)

5 (35 ILCS 200/21-27)

6 Sec. 21-27. Waiver of interest penalty.

7 (a) On the recommendation of the county treasurer, the
8 county board may adopt a resolution under which an interest
9 penalty for the delinquent payment of taxes for any year that
10 otherwise would be imposed under Section 21-15, 21-20, or 21-25
11 shall be waived in the case of any person who meets all of the
12 following criteria:

13 (1) The person is determined eligible for a grant under
14 the Senior Citizens and Disabled Persons Property Tax
15 Relief ~~and Pharmaceutical Assistance~~ Act with respect to
16 the taxes for that year.

17 (2) The person requests, in writing, on a form approved
18 by the county treasurer, a waiver of the interest penalty,
19 and the request is filed with the county treasurer on or
20 before the first day of the month that an installment of
21 taxes is due.

22 (3) The person pays the installment of taxes due, in
23 full, on or before the third day of the month that the
24 installment is due.

25 (4) The county treasurer approves the request for a

1 waiver.

2 (b) With respect to property that qualifies as a brownfield
3 site under Section 58.2 of the Environmental Protection Act,
4 the county board, upon the recommendation of the county
5 treasurer, may adopt a resolution to waive an interest penalty
6 for the delinquent payment of taxes for any year that otherwise
7 would be imposed under Section 21-15, 21-20, or 21-25 if all of
8 the following criteria are met:

9 (1) the property has delinquent taxes and an
10 outstanding interest penalty and the amount of that
11 interest penalty is so large as to, possibly, result in all
12 of the taxes becoming uncollectible;

13 (2) the property is part of a redevelopment plan of a
14 unit of local government and that unit of local government
15 does not oppose the waiver of the interest penalty;

16 (3) the redevelopment of the property will benefit the
17 public interest by remediating the brownfield
18 contamination;

19 (4) the taxpayer delivers to the county treasurer (i) a
20 written request for a waiver of the interest penalty, on a
21 form approved by the county treasurer, and (ii) a copy of
22 the redevelopment plan for the property;

23 (5) the taxpayer pays, in full, the amount of up to the
24 amount of the first 2 installments of taxes due, to be held
25 in escrow pending the approval of the waiver, and enters
26 into an agreement with the county treasurer setting forth a

1 schedule for the payment of any remaining taxes due; and
2 (6) the county treasurer approves the request for a
3 waiver.

4 (Source: P.A. 97-655, eff. 1-13-12.)

5 Section 925. The Mobile Home Local Services Tax Act is
6 amended by changing Section 7 as follows:

7 (35 ILCS 515/7) (from Ch. 120, par. 1207)

8 Sec. 7. The local services tax for owners of mobile homes
9 who (a) are actually residing in such mobile homes, (b) hold
10 title to such mobile home as provided in the Illinois Vehicle
11 Code, and (c) are 65 years of age or older or are disabled
12 persons within the meaning of Section 3.14 of the "Senior
13 Citizens and Disabled Persons Property Tax Relief ~~and~~
14 ~~Pharmaceutical Assistance~~ Act" on the annual billing date shall
15 be reduced to 80 percent of the tax provided for in Section 3
16 of this Act. Proof that a claimant has been issued an Illinois
17 Disabled Person Identification Card stating that the claimant
18 is under a Class 2 disability, as provided in Section 4A of the
19 Illinois Identification Card Act, shall constitute proof that
20 the person thereon named is a disabled person within the
21 meaning of this Act. An application for reduction of the tax
22 shall be filed with the county clerk by the individuals who are
23 entitled to the reduction. If the application is filed after
24 May 1, the reduction in tax shall begin with the next annual

1 bill. Application for the reduction in tax shall be done by
2 submitting proof that the applicant has been issued an Illinois
3 Disabled Person Identification Card designating the
4 applicant's disability as a Class 2 disability, or by affidavit
5 in substantially the following form:

6 APPLICATION FOR REDUCTION OF MOBILE HOME LOCAL SERVICES TAX

7 I hereby make application for a reduction to 80% of the
8 total tax imposed under "An Act to provide for a local services
9 tax on mobile homes".

10 (1) Senior Citizens

11 (a) I actually reside in the mobile home

12 (b) I hold title to the mobile home as provided in the
13 Illinois Vehicle Code

14 (c) I reached the age of 65 on or before either January 1
15 (or July 1) of the year in which this statement is filed. My
16 date of birth is: ...

17 (2) Disabled Persons

18 (a) I actually reside in the mobile home...

19 (b) I hold title to the mobile home as provided in the
20 Illinois Vehicle Code

21 (c) I was totally disabled on ... and have remained
22 disabled until the date of this application. My Social
23 Security, Veterans, Railroad or Civil Service Total Disability
24 Claim Number is ... The undersigned declares under the penalty
25 of perjury that the above statements are true and correct.

26 Dated (insert date).

1
 2 Signature of owner
 3
 4 (Address)
 5
 6 (City) (State) (Zip)

7 Approved by:
 8
 9 (Assessor)

10 This application shall be accompanied by a copy of the
 11 applicant's most recent application filed with the Illinois
 12 Department on Aging under the Senior Citizens and Disabled
 13 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~ Act.
 14 (Source: P.A. 96-804, eff. 1-1-10.)

15 Section 930. The Metropolitan Transit Authority Act is
 16 amended by changing Sections 51 and 52 as follows:

17 (70 ILCS 3605/51)
 18 Sec. 51. Free services; eligibility.
 19 (a) Notwithstanding any law to the contrary, no later than
 20 60 days following the effective date of this amendatory Act of
 21 the 95th General Assembly and until subsection (b) is
 22 implemented, any fixed route public transportation services
 23 provided by, or under grant or purchase of service contracts

1 of, the Board shall be provided without charge to all senior
2 citizens of the Metropolitan Region (as such term is defined in
3 70 ILCS 3615/1.03) aged 65 and older, under such conditions as
4 shall be prescribed by the Board.

5 (b) Notwithstanding any law to the contrary, no later than
6 180 days following the effective date of this amendatory Act of
7 the 96th General Assembly, any fixed route public
8 transportation services provided by, or under grant or purchase
9 of service contracts of, the Board shall be provided without
10 charge to senior citizens aged 65 and older who meet the income
11 eligibility limitation set forth in subsection (a-5) of Section
12 4 of the Senior Citizens and Disabled Persons Property Tax
13 Relief ~~and Pharmaceutical Assistance~~ Act, under such
14 conditions as shall be prescribed by the Board. The Department
15 on Aging shall furnish all information reasonably necessary to
16 determine eligibility, including updated lists of individuals
17 who are eligible for services without charge under this
18 Section. Nothing in this Section shall relieve the Board from
19 providing reduced fares as may be required by federal law.

20 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

21 (70 ILCS 3605/52)

22 Sec. 52. Transit services for disabled individuals.
23 Notwithstanding any law to the contrary, no later than 60 days
24 following the effective date of this amendatory Act of the 95th
25 General Assembly, all fixed route public transportation

1 services provided by, or under grant or purchase of service
2 contract of, the Board shall be provided without charge to all
3 disabled persons who meet the income eligibility limitation set
4 forth in subsection (a-5) of Section 4 of the Senior Citizens
5 and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
6 ~~Assistance~~ Act, under such procedures as shall be prescribed by
7 the Board. The Department on Aging shall furnish all
8 information reasonably necessary to determine eligibility,
9 including updated lists of individuals who are eligible for
10 services without charge under this Section.

11 (Source: P.A. 95-906, eff. 8-26-08.)

12 Section 935. The Local Mass Transit District Act is amended
13 by changing Sections 8.6 and 8.7 as follows:

14 (70 ILCS 3610/8.6)

15 Sec. 8.6. Free services; eligibility.

16 (a) Notwithstanding any law to the contrary, no later than
17 60 days following the effective date of this amendatory Act of
18 the 95th General Assembly and until subsection (b) is
19 implemented, any fixed route public transportation services
20 provided by, or under grant or purchase of service contracts
21 of, every District shall be provided without charge to all
22 senior citizens of the District aged 65 and older, under such
23 conditions as shall be prescribed by the District.

24 (b) Notwithstanding any law to the contrary, no later than

1 180 days following the effective date of this amendatory Act of
2 the 96th General Assembly, any fixed route public
3 transportation services provided by, or under grant or purchase
4 of service contracts of, every District shall be provided
5 without charge to senior citizens aged 65 and older who meet
6 the income eligibility limitation set forth in subsection (a-5)
7 of Section 4 of the Senior Citizens and Disabled Persons
8 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, under
9 such conditions as shall be prescribed by the District. The
10 Department on Aging shall furnish all information reasonably
11 necessary to determine eligibility, including updated lists of
12 individuals who are eligible for services without charge under
13 this Section. Nothing in this Section shall relieve the
14 District from providing reduced fares as may be required by
15 federal law.

16 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

17 (70 ILCS 3610/8.7)

18 Sec. 8.7. Transit services for disabled individuals.
19 Notwithstanding any law to the contrary, no later than 60 days
20 following the effective date of this amendatory Act of the 95th
21 General Assembly, all fixed route public transportation
22 services provided by, or under grant or purchase of service
23 contract of, any District shall be provided without charge to
24 all disabled persons who meet the income eligibility limitation
25 set forth in subsection (a-5) of Section 4 of the Senior

1 Citizens and Disabled Persons Property Tax Relief ~~and~~
2 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
3 be prescribed by the District. The Department on Aging shall
4 furnish all information reasonably necessary to determine
5 eligibility, including updated lists of individuals who are
6 eligible for services without charge under this Section.

7 (Source: P.A. 95-906, eff. 8-26-08.)

8 Section 940. The Regional Transportation Authority Act is
9 amended by changing Sections 3A.15, 3A.16, 3B.14, and 3B.15 as
10 follows:

11 (70 ILCS 3615/3A.15)

12 Sec. 3A.15. Free services; eligibility.

13 (a) Notwithstanding any law to the contrary, no later than
14 60 days following the effective date of this amendatory Act of
15 the 95th General Assembly and until subsection (b) is
16 implemented, any fixed route public transportation services
17 provided by, or under grant or purchase of service contracts
18 of, the Suburban Bus Board shall be provided without charge to
19 all senior citizens of the Metropolitan Region aged 65 and
20 older, under such conditions as shall be prescribed by the
21 Suburban Bus Board.

22 (b) Notwithstanding any law to the contrary, no later than
23 180 days following the effective date of this amendatory Act of
24 the 96th General Assembly, any fixed route public

1 transportation services provided by, or under grant or purchase
2 of service contracts of, the Suburban Bus Board shall be
3 provided without charge to senior citizens aged 65 and older
4 who meet the income eligibility limitation set forth in
5 subsection (a-5) of Section 4 of the Senior Citizens and
6 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
7 ~~Assistance~~ Act, under such conditions as shall be prescribed by
8 the Suburban Bus Board. The Department on Aging shall furnish
9 all information reasonably necessary to determine eligibility,
10 including updated lists of individuals who are eligible for
11 services without charge under this Section. Nothing in this
12 Section shall relieve the Suburban Bus Board from providing
13 reduced fares as may be required by federal law.

14 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

15 (70 ILCS 3615/3A.16)

16 Sec. 3A.16. Transit services for disabled individuals.
17 Notwithstanding any law to the contrary, no later than 60 days
18 following the effective date of this amendatory Act of the 95th
19 General Assembly, all fixed route public transportation
20 services provided by, or under grant or purchase of service
21 contract of, the Suburban Bus Board shall be provided without
22 charge to all disabled persons who meet the income eligibility
23 limitation set forth in subsection (a-5) of Section 4 of the
24 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
25 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall

1 be prescribed by the Board. The Department on Aging shall
2 furnish all information reasonably necessary to determine
3 eligibility, including updated lists of individuals who are
4 eligible for services without charge under this Section.

5 (Source: P.A. 95-906, eff. 8-26-08.)

6 (70 ILCS 3615/3B.14)

7 Sec. 3B.14. Free services; eligibility.

8 (a) Notwithstanding any law to the contrary, no later than
9 60 days following the effective date of this amendatory Act of
10 the 95th General Assembly and until subsection (b) is
11 implemented, any fixed route public transportation services
12 provided by, or under grant or purchase of service contracts
13 of, the Commuter Rail Board shall be provided without charge to
14 all senior citizens of the Metropolitan Region aged 65 and
15 older, under such conditions as shall be prescribed by the
16 Commuter Rail Board.

17 (b) Notwithstanding any law to the contrary, no later than
18 180 days following the effective date of this amendatory Act of
19 the 96th General Assembly, any fixed route public
20 transportation services provided by, or under grant or purchase
21 of service contracts of, the Commuter Rail Board shall be
22 provided without charge to senior citizens aged 65 and older
23 who meet the income eligibility limitation set forth in
24 subsection (a-5) of Section 4 of the Senior Citizens and
25 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~

1 ~~Assistance~~ Act, under such conditions as shall be prescribed by
2 the Commuter Rail Board. The Department on Aging shall furnish
3 all information reasonably necessary to determine eligibility,
4 including updated lists of individuals who are eligible for
5 services without charge under this Section. Nothing in this
6 Section shall relieve the Commuter Rail Board from providing
7 reduced fares as may be required by federal law.

8 (Source: P.A. 95-708, eff. 1-18-08; 96-1527, eff. 2-14-11.)

9 (70 ILCS 3615/3B.15)

10 Sec. 3B.15. Transit services for disabled individuals.
11 Notwithstanding any law to the contrary, no later than 60 days
12 following the effective date of this amendatory Act of the 95th
13 General Assembly, all fixed route public transportation
14 services provided by, or under grant or purchase of service
15 contract of, the Commuter Rail Board shall be provided without
16 charge to all disabled persons who meet the income eligibility
17 limitation set forth in subsection (a-5) of Section 4 of the
18 Senior Citizens and Disabled Persons Property Tax Relief ~~and~~
19 ~~Pharmaceutical Assistance~~ Act, under such procedures as shall
20 be prescribed by the Board. The Department on Aging shall
21 furnish all information reasonably necessary to determine
22 eligibility, including updated lists of individuals who are
23 eligible for services without charge under this Section.

24 (Source: P.A. 95-906, eff. 8-26-08.)

1 Section 945. The Senior Citizen Courses Act is amended by
2 changing Section 1 as follows:

3 (110 ILCS 990/1) (from Ch. 144, par. 1801)

4 Sec. 1. Definitions. For the purposes of this Act:

5 (a) "Public institutions of higher education" means the
6 University of Illinois, Southern Illinois University, Chicago
7 State University, Eastern Illinois University, Governors State
8 University, Illinois State University, Northeastern Illinois
9 University, Northern Illinois University, Western Illinois
10 University, and the public community colleges subject to the
11 "Public Community College Act".

12 (b) "Credit Course" means any program of study for which
13 public institutions of higher education award credit hours.

14 (c) "Senior citizen" means any person 65 years or older
15 whose annual household income is less than the threshold amount
16 provided in Section 4 of the "Senior Citizens and Disabled
17 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~
18 Act", approved July 17, 1972, as amended.

19 (Source: P.A. 89-4, eff. 1-1-96.)

20 Section 950. The Citizens Utility Board Act is amended by
21 changing Section 9 as follows:

22 (220 ILCS 10/9) (from Ch. 111 2/3, par. 909)

23 Sec. 9. Mailing procedure.

1 (1) As used in this Section:

2 (a) "Enclosure" means a card, leaflet, envelope or
3 combination thereof furnished by the corporation under
4 this Section.

5 (b) "Mailing" means any communication by a State
6 agency, other than a mailing made under the Senior Citizens
7 and Disabled Persons Property Tax Relief ~~and~~
8 ~~Pharmaceutical Assistance~~ Act, that is sent through the
9 United States Postal Service to more than 50,000 persons
10 within a 12-month period.

11 (c) "State agency" means any officer, department,
12 board, commission, institution or entity of the executive
13 or legislative branches of State government.

14 (2) To accomplish its powers and duties under Section 5
15 this Act, the corporation, subject to the following
16 limitations, may prepare and furnish to any State agency an
17 enclosure to be included with a mailing by that agency.

18 (a) A State agency furnished with an enclosure shall
19 include the enclosure within the mailing designated by the
20 corporation.

21 (b) An enclosure furnished by the corporation under
22 this Section shall be provided to the State agency a
23 reasonable period of time in advance of the mailing.

24 (c) An enclosure furnished by the corporation under
25 this Section shall be limited to informing the reader of
26 the purpose, nature and activities of the corporation as

1 set forth in this Act and informing the reader that it may
2 become a member in the corporation, maintain membership in
3 the corporation and contribute money to the corporation
4 directly.

5 (d) Prior to furnishing an enclosure to the State
6 agency, the corporation shall seek and obtain approval of
7 the content of the enclosure from the Illinois Commerce
8 Commission. The Commission shall approve the enclosure if
9 it determines that the enclosure (i) is not false or
10 misleading and (ii) satisfies the requirements of this Act.
11 The Commission shall be deemed to have approved the
12 enclosure unless it disapproves the enclosure within 14
13 days from the date of receipt.

14 (3) The corporation shall reimburse each State agency for
15 all reasonable incremental costs incurred by the State agency
16 in complying with this Section above the agency's normal
17 mailing and handling costs, provided that:

18 (a) The State agency shall first furnish the
19 corporation with an itemized accounting of such additional
20 cost; and

21 (b) The corporation shall not be required to reimburse
22 the State agency for postage costs if the weight of the
23 corporation's enclosure does not exceed .35 ounce
24 avoirdupois. If the corporation's enclosure exceeds that
25 weight, then it shall only be required to reimburse the
26 State agency for postage cost over and above what the

1 agency's postage cost would have been had the enclosure
2 weighed only .35 ounce avoirdupois.

3 (Source: P.A. 96-804, eff. 1-1-10.)

4 Section 955. The Illinois Public Aid Code is amended by
5 changing Sections 3-5, 4-1.6, 4-2, 6-1.2, 6-2, and 12-9 as
6 follows:

7 (305 ILCS 5/3-5) (from Ch. 23, par. 3-5)

8 Sec. 3-5. Amount of aid. The amount and nature of financial
9 aid granted to or in behalf of aged, blind, or disabled persons
10 shall be determined in accordance with the standards, grant
11 amounts, rules and regulations of the Illinois Department. Due
12 regard shall be given to the requirements and conditions
13 existing in each case, and to the amount of property owned and
14 the income, money contributions, and other support, and
15 resources received or obtainable by the person, from whatever
16 source. However, the amount and nature of any financial aid is
17 not affected by the payment of any grant under the "Senior
18 Citizens and Disabled Persons Property Tax Relief ~~and~~
19 ~~Pharmaceutical Assistance Act~~" or any distributions or items of
20 income described under subparagraph (X) of paragraph (2) of
21 subsection (a) of Section 203 of the Illinois Income Tax Act.
22 The aid shall be sufficient, when added to all other income,
23 money contributions and support, to provide the person with a
24 grant in the amount established by Department regulation for

1 such a person, based upon standards providing a livelihood
2 compatible with health and well-being. Financial aid under this
3 Article granted to persons who have been found ineligible for
4 Supplemental Security Income (SSI) due to expiration of the
5 period of eligibility for refugees and asylees pursuant to 8
6 U.S.C. 1612(a)(2) shall not exceed \$500 per month.

7 (Source: P.A. 93-741, eff. 7-15-04.)

8 (305 ILCS 5/4-1.6) (from Ch. 23, par. 4-1.6)

9 Sec. 4-1.6. Need. Income available to the family as defined
10 by the Illinois Department by rule, or to the child in the case
11 of a child removed from his or her home, when added to
12 contributions in money, substance or services from other
13 sources, including income available from parents absent from
14 the home or from a stepparent, contributions made for the
15 benefit of the parent or other persons necessary to provide
16 care and supervision to the child, and contributions from
17 legally responsible relatives, must be equal to or less than
18 the grant amount established by Department regulation for such
19 a person. For purposes of eligibility for aid under this
20 Article, the Department shall disregard all earned income
21 between the grant amount and 50% of the Federal Poverty Level.

22 In considering income to be taken into account,
23 consideration shall be given to any expenses reasonably
24 attributable to the earning of such income. Three-fourths of
25 the earned income of a household eligible for aid under this

1 Article shall be disregarded when determining the level of
2 assistance for which a household is eligible. The Illinois
3 Department may also permit all or any portion of earned or
4 other income to be set aside for the future identifiable needs
5 of a child. The Illinois Department may provide by rule and
6 regulation for the exemptions thus permitted or required. The
7 eligibility of any applicant for or recipient of public aid
8 under this Article is not affected by the payment of any grant
9 under the "Senior Citizens and Disabled Persons Property Tax
10 Relief ~~and Pharmaceutical Assistance Act~~" or any distributions
11 or items of income described under subparagraph (X) of
12 paragraph (2) of subsection (a) of Section 203 of the Illinois
13 Income Tax Act.

14 The Illinois Department may, by rule, set forth criteria
15 under which an assistance unit is ineligible for cash
16 assistance under this Article for a specified number of months
17 due to the receipt of a lump sum payment.

18 (Source: P.A. 96-866, eff. 7-1-10.)

19 (305 ILCS 5/4-2) (from Ch. 23, par. 4-2)

20 Sec. 4-2. Amount of aid.

21 (a) The amount and nature of financial aid shall be
22 determined in accordance with the grant amounts, rules and
23 regulations of the Illinois Department. Due regard shall be
24 given to the self-sufficiency requirements of the family and to
25 the income, money contributions and other support and resources

1 available, from whatever source. However, the amount and nature
2 of any financial aid is not affected by the payment of any
3 grant under the "Senior Citizens and Disabled Persons Property
4 Tax Relief ~~and Pharmaceutical Assistance~~ Act" or any
5 distributions or items of income described under subparagraph
6 (X) of paragraph (2) of subsection (a) of Section 203 of the
7 Illinois Income Tax Act. The aid shall be sufficient, when
8 added to all other income, money contributions and support to
9 provide the family with a grant in the amount established by
10 Department regulation.

11 Subject to appropriation, beginning on July 1, 2008, the
12 Department of Human Services shall increase TANF grant amounts
13 in effect on June 30, 2008 by 15%. The Department is authorized
14 to administer this increase but may not otherwise adopt any
15 rule to implement this increase.

16 (b) The Illinois Department may conduct special projects,
17 which may be known as Grant Diversion Projects, under which
18 recipients of financial aid under this Article are placed in
19 jobs and their grants are diverted to the employer who in turn
20 makes payments to the recipients in the form of salary or other
21 employment benefits. The Illinois Department shall by rule
22 specify the terms and conditions of such Grant Diversion
23 Projects. Such projects shall take into consideration and be
24 coordinated with the programs administered under the Illinois
25 Emergency Employment Development Act.

26 (c) The amount and nature of the financial aid for a child

1 requiring care outside his own home shall be determined in
2 accordance with the rules and regulations of the Illinois
3 Department, with due regard to the needs and requirements of
4 the child in the foster home or institution in which he has
5 been placed.

6 (d) If the Department establishes grants for family units
7 consisting exclusively of a pregnant woman with no dependent
8 child or including her husband if living with her, the grant
9 amount for such a unit shall be equal to the grant amount for
10 an assistance unit consisting of one adult, or 2 persons if the
11 husband is included. Other than as herein described, an unborn
12 child shall not be counted in determining the size of an
13 assistance unit or for calculating grants.

14 Payments for basic maintenance requirements of a child or
15 children and the relative with whom the child or children are
16 living shall be prescribed, by rule, by the Illinois
17 Department.

18 Grants under this Article shall not be supplemented by
19 General Assistance provided under Article VI.

20 (e) Grants shall be paid to the parent or other person with
21 whom the child or children are living, except for such amount
22 as is paid in behalf of the child or his parent or other
23 relative to other persons or agencies pursuant to this Code or
24 the rules and regulations of the Illinois Department.

25 (f) Subject to subsection (f-5), an assistance unit,
26 receiving financial aid under this Article or temporarily

1 ineligible to receive aid under this Article under a penalty
2 imposed by the Illinois Department for failure to comply with
3 the eligibility requirements or that voluntarily requests
4 termination of financial assistance under this Article and
5 becomes subsequently eligible for assistance within 9 months,
6 shall not receive any increase in the amount of aid solely on
7 account of the birth of a child; except that an increase is not
8 prohibited when the birth is (i) of a child of a pregnant woman
9 who became eligible for aid under this Article during the
10 pregnancy, or (ii) of a child born within 10 months after the
11 date of implementation of this subsection, or (iii) of a child
12 conceived after a family became ineligible for assistance due
13 to income or marriage and at least 3 months of ineligibility
14 expired before any reapplication for assistance. This
15 subsection does not, however, prevent a unit from receiving a
16 general increase in the amount of aid that is provided to all
17 recipients of aid under this Article.

18 The Illinois Department is authorized to transfer funds,
19 and shall use any budgetary savings attributable to not
20 increasing the grants due to the births of additional children,
21 to supplement existing funding for employment and training
22 services for recipients of aid under this Article IV. The
23 Illinois Department shall target, to the extent the
24 supplemental funding allows, employment and training services
25 to the families who do not receive a grant increase after the
26 birth of a child. In addition, the Illinois Department shall

1 provide, to the extent the supplemental funding allows, such
2 families with up to 24 months of transitional child care
3 pursuant to Illinois Department rules. All remaining
4 supplemental funds shall be used for employment and training
5 services or transitional child care support.

6 In making the transfers authorized by this subsection, the
7 Illinois Department shall first determine, pursuant to
8 regulations adopted by the Illinois Department for this
9 purpose, the amount of savings attributable to not increasing
10 the grants due to the births of additional children. Transfers
11 may be made from General Revenue Fund appropriations for
12 distributive purposes authorized by Article IV of this Code
13 only to General Revenue Fund appropriations for employability
14 development services including operating and administrative
15 costs and related distributive purposes under Article IXA of
16 this Code. The Director, with the approval of the Governor,
17 shall certify the amount and affected line item appropriations
18 to the State Comptroller.

19 Nothing in this subsection shall be construed to prohibit
20 the Illinois Department from using funds under this Article IV
21 to provide assistance in the form of vouchers that may be used
22 to pay for goods and services deemed by the Illinois
23 Department, by rule, as suitable for the care of the child such
24 as diapers, clothing, school supplies, and cribs.

25 (f-5) Subsection (f) shall not apply to affect the monthly
26 assistance amount of any family as a result of the birth of a

1 child on or after January 1, 2004. As resources permit after
2 January 1, 2004, the Department may cease applying subsection
3 (f) to limit assistance to families receiving assistance under
4 this Article on January 1, 2004, with respect to children born
5 prior to that date. In any event, subsection (f) shall be
6 completely inoperative on and after July 1, 2007.

7 (g) (Blank).

8 (h) Notwithstanding any other provision of this Code, the
9 Illinois Department is authorized to reduce payment levels used
10 to determine cash grants under this Article after December 31
11 of any fiscal year if the Illinois Department determines that
12 the caseload upon which the appropriations for the current
13 fiscal year are based have increased by more than 5% and the
14 appropriation is not sufficient to ensure that cash benefits
15 under this Article do not exceed the amounts appropriated for
16 those cash benefits. Reductions in payment levels may be
17 accomplished by emergency rule under Section 5-45 of the
18 Illinois Administrative Procedure Act, except that the
19 limitation on the number of emergency rules that may be adopted
20 in a 24-month period shall not apply and the provisions of
21 Sections 5-115 and 5-125 of the Illinois Administrative
22 Procedure Act shall not apply. Increases in payment levels
23 shall be accomplished only in accordance with Section 5-40 of
24 the Illinois Administrative Procedure Act. Before any rule to
25 increase payment levels promulgated under this Section shall
26 become effective, a joint resolution approving the rule must be

1 adopted by a roll call vote by a majority of the members
2 elected to each chamber of the General Assembly.

3 (Source: P.A. 95-744, eff. 7-18-08; 95-1055, eff. 4-10-09;
4 96-1000, eff. 7-2-10.)

5 (305 ILCS 5/6-1.2) (from Ch. 23, par. 6-1.2)

6 Sec. 6-1.2. Need. Income available to the person, when
7 added to contributions in money, substance, or services from
8 other sources, including contributions from legally
9 responsible relatives, must be insufficient to equal the grant
10 amount established by Department regulation (or by local
11 governmental unit in units which do not receive State funds)
12 for such a person.

13 In determining income to be taken into account:

14 (1) The first \$75 of earned income in income assistance
15 units comprised exclusively of one adult person shall be
16 disregarded, and for not more than 3 months in any 12
17 consecutive months that portion of earned income beyond the
18 first \$75 that is the difference between the standard of
19 assistance and the grant amount, shall be disregarded.

20 (2) For income assistance units not comprised
21 exclusively of one adult person, when authorized by rules
22 and regulations of the Illinois Department, a portion of
23 earned income, not to exceed the first \$25 a month plus 50%
24 of the next \$75, may be disregarded for the purpose of
25 stimulating and aiding rehabilitative effort and

1 self-support activity.

2 "Earned income" means money earned in self-employment or
3 wages, salary, or commission for personal services performed as
4 an employee. The eligibility of any applicant for or recipient
5 of public aid under this Article is not affected by the payment
6 of any grant under the "Senior Citizens and Disabled Persons
7 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act", any
8 refund or payment of the federal Earned Income Tax Credit, or
9 any distributions or items of income described under
10 subparagraph (X) of paragraph (2) of subsection (a) of Section
11 203 of the Illinois Income Tax Act.

12 (Source: P.A. 91-676, eff. 12-23-99; 92-111, eff. 1-1-02.)

13 (305 ILCS 5/6-2) (from Ch. 23, par. 6-2)

14 Sec. 6-2. Amount of aid. The amount and nature of General
15 Assistance for basic maintenance requirements shall be
16 determined in accordance with local budget standards for local
17 governmental units which do not receive State funds. For local
18 governmental units which do receive State funds, the amount and
19 nature of General Assistance for basic maintenance
20 requirements shall be determined in accordance with the
21 standards, rules and regulations of the Illinois Department.
22 However, the amount and nature of any financial aid is not
23 affected by the payment of any grant under the Senior Citizens
24 and Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
25 ~~Assistance~~ Act or any distributions or items of income

1 described under subparagraph (X) of paragraph (2) of subsection
2 (a) of Section 203 of the Illinois Income Tax Act. Due regard
3 shall be given to the requirements and the conditions existing
4 in each case, and to the income, money contributions and other
5 support and resources available, from whatever source. In local
6 governmental units which do not receive State funds, the grant
7 shall be sufficient when added to all other income, money
8 contributions and support in excess of any excluded income or
9 resources, to provide the person with a grant in the amount
10 established for such a person by the local governmental unit
11 based upon standards meeting basic maintenance requirements.
12 In local governmental units which do receive State funds, the
13 grant shall be sufficient when added to all other income, money
14 contributions and support in excess of any excluded income or
15 resources, to provide the person with a grant in the amount
16 established for such a person by Department regulation based
17 upon standards providing a livelihood compatible with health
18 and well-being, as directed by Section 12-4.11 of this Code.

19 The Illinois Department may conduct special projects,
20 which may be known as Grant Diversion Projects, under which
21 recipients of financial aid under this Article are placed in
22 jobs and their grants are diverted to the employer who in turn
23 makes payments to the recipients in the form of salary or other
24 employment benefits. The Illinois Department shall by rule
25 specify the terms and conditions of such Grant Diversion
26 Projects. Such projects shall take into consideration and be

1 coordinated with the programs administered under the Illinois
2 Emergency Employment Development Act.

3 The allowances provided under Article IX for recipients
4 participating in the training and rehabilitation programs
5 shall be in addition to such maximum payment.

6 Payments may also be made to provide persons receiving
7 basic maintenance support with necessary treatment, care and
8 supplies required because of illness or disability or with
9 acute medical treatment, care, and supplies. Payments for
10 necessary or acute medical care under this paragraph may be
11 made to or in behalf of the person. Obligations incurred for
12 such services but not paid for at the time of a recipient's
13 death may be paid, subject to the rules and regulations of the
14 Illinois Department, after the death of the recipient.

15 (Source: P.A. 91-676, eff. 12-23-99; 92-111, eff. 1-1-02.)

16 (305 ILCS 5/12-9) (from Ch. 23, par. 12-9)

17 Sec. 12-9. Public Aid Recoveries Trust Fund; uses. The
18 Public Aid Recoveries Trust Fund shall consist of (1)
19 recoveries by the Department of Healthcare and Family Services
20 (formerly Illinois Department of Public Aid) authorized by this
21 Code in respect to applicants or recipients under Articles III,
22 IV, V, and VI, including recoveries made by the Department of
23 Healthcare and Family Services (formerly Illinois Department
24 of Public Aid) from the estates of deceased recipients, (2)
25 recoveries made by the Department of Healthcare and Family

1 Services (formerly Illinois Department of Public Aid) in
2 respect to applicants and recipients under the Children's
3 Health Insurance Program Act, and the Covering ALL KIDS Health
4 Insurance Act, ~~and the Senior Citizens and Disabled Persons
5 Property Tax Relief and Pharmaceutical Assistance Act,~~ (3)
6 federal funds received on behalf of and earned by State
7 universities and local governmental entities for services
8 provided to applicants or recipients covered under this Code,
9 the Children's Health Insurance Program Act, and the Covering
10 ALL KIDS Health Insurance Act, ~~and the Senior Citizens and
11 Disabled Persons Property Tax Relief and Pharmaceutical
12 Assistance Act,~~ (3.5) federal financial participation revenue
13 related to eligible disbursements made by the Department of
14 Healthcare and Family Services from appropriations required by
15 this Section, and (4) all other moneys received to the Fund,
16 including interest thereon. The Fund shall be held as a special
17 fund in the State Treasury.

18 Disbursements from this Fund shall be only (1) for the
19 reimbursement of claims collected by the Department of
20 Healthcare and Family Services (formerly Illinois Department
21 of Public Aid) through error or mistake, (2) for payment to
22 persons or agencies designated as payees or co-payees on any
23 instrument, whether or not negotiable, delivered to the
24 Department of Healthcare and Family Services (formerly
25 Illinois Department of Public Aid) as a recovery under this
26 Section, such payment to be in proportion to the respective

1 interests of the payees in the amount so collected, (3) for
2 payments to the Department of Human Services for collections
3 made by the Department of Healthcare and Family Services
4 (formerly Illinois Department of Public Aid) on behalf of the
5 Department of Human Services under this Code, the Children's
6 Health Insurance Program Act, and the Covering ALL KIDS Health
7 Insurance Act, (4) for payment of administrative expenses
8 incurred in performing the activities authorized under this
9 Code, the Children's Health Insurance Program Act, and the
10 Covering ALL KIDS Health Insurance Act, ~~and the Senior Citizens
11 and Disabled Persons Property Tax Relief and Pharmaceutical
12 Assistance Act,~~ (5) for payment of fees to persons or agencies
13 in the performance of activities pursuant to the collection of
14 monies owed the State that are collected under this Code, the
15 Children's Health Insurance Program Act, and the Covering ALL
16 KIDS Health Insurance Act, ~~and the Senior Citizens and Disabled
17 Persons Property Tax Relief and Pharmaceutical Assistance Act,~~
18 (6) for payments of any amounts which are reimbursable to the
19 federal government which are required to be paid by State
20 warrant by either the State or federal government, and (7) for
21 payments to State universities and local governmental entities
22 of federal funds for services provided to applicants or
23 recipients covered under this Code, the Children's Health
24 Insurance Program Act, and the Covering ALL KIDS Health
25 Insurance Act, ~~and the Senior Citizens and Disabled Persons
26 Property Tax Relief and Pharmaceutical Assistance Act.~~

1 Disbursements from this Fund for purposes of items (4) and (5)
2 of this paragraph shall be subject to appropriations from the
3 Fund to the Department of Healthcare and Family Services
4 (formerly Illinois Department of Public Aid).

5 The balance in this Fund on the first day of each calendar
6 quarter, after payment therefrom of any amounts reimbursable to
7 the federal government, and minus the amount reasonably
8 anticipated to be needed to make the disbursements during that
9 quarter authorized by this Section, shall be certified by the
10 Director of Healthcare and Family Services and transferred by
11 the State Comptroller to the Drug Rebate Fund or the Healthcare
12 Provider Relief Fund in the State Treasury, as appropriate,
13 within 30 days of the first day of each calendar quarter. The
14 Director of Healthcare and Family Services may certify and the
15 State Comptroller shall transfer to the Drug Rebate Fund
16 amounts on a more frequent basis.

17 On July 1, 1999, the State Comptroller shall transfer the
18 sum of \$5,000,000 from the Public Aid Recoveries Trust Fund
19 (formerly the Public Assistance Recoveries Trust Fund) into the
20 DHS Recoveries Trust Fund.

21 (Source: P.A. 96-1100, eff. 1-1-11; 97-647, eff. 1-1-12.)

22 Section 960. The Senior Citizens Real Estate Tax Deferral
23 Act is amended by changing Sections 2 and 8 as follows:

24 (320 ILCS 30/2) (from Ch. 67 1/2, par. 452)

1 Sec. 2. Definitions. As used in this Act:

2 (a) "Taxpayer" means an individual whose household income
3 for the year is no greater than: (i) \$40,000 through tax year
4 2005; (ii) \$50,000 for tax years 2006 through 2011; and (iii)
5 \$55,000 for tax year 2012 and thereafter.

6 (b) "Tax deferred property" means the property upon which
7 real estate taxes are deferred under this Act.

8 (c) "Homestead" means the land and buildings thereon,
9 including a condominium or a dwelling unit in a multidwelling
10 building that is owned and operated as a cooperative, occupied
11 by the taxpayer as his residence or which are temporarily
12 unoccupied by the taxpayer because such taxpayer is temporarily
13 residing, for not more than 1 year, in a licensed facility as
14 defined in Section 1-113 of the Nursing Home Care Act.

15 (d) "Real estate taxes" or "taxes" means the taxes on real
16 property for which the taxpayer would be liable under the
17 Property Tax Code, including special service area taxes, and
18 special assessments on benefited real property for which the
19 taxpayer would be liable to a unit of local government.

20 (e) "Department" means the Department of Revenue.

21 (f) "Qualifying property" means a homestead which (a) the
22 taxpayer or the taxpayer and his spouse own in fee simple or
23 are purchasing in fee simple under a recorded instrument of
24 sale, (b) is not income-producing property, (c) is not subject
25 to a lien for unpaid real estate taxes when a claim under this
26 Act is filed, and (d) is not held in trust, other than an

1 Illinois land trust with the taxpayer identified as the sole
2 beneficiary, if the taxpayer is filing for the program for the
3 first time effective as of the January 1, 2011 assessment year
4 or tax year 2012 and thereafter.

5 (g) "Equity interest" means the current assessed valuation
6 of the qualified property times the fraction necessary to
7 convert that figure to full market value minus any outstanding
8 debts or liens on that property. In the case of qualifying
9 property not having a separate assessed valuation, the
10 appraised value as determined by a qualified real estate
11 appraiser shall be used instead of the current assessed
12 valuation.

13 (h) "Household income" has the meaning ascribed to that
14 term in the Senior Citizens and Disabled Persons Property Tax
15 Relief ~~and Pharmaceutical Assistance~~ Act.

16 (i) "Collector" means the county collector or, if the taxes
17 to be deferred are special assessments, an official designated
18 by a unit of local government to collect special assessments.

19 (Source: P.A. 97-481, eff. 8-22-11.)

20 (320 ILCS 30/8) (from Ch. 67 1/2, par. 458)

21 Sec. 8. Nothing in this Act (a) affects any provision of
22 any mortgage or other instrument relating to land requiring a
23 person to pay real estate taxes or (b) affects the eligibility
24 of any person to receive any grant pursuant to the "Senior
25 Citizens and Disabled Persons Property Tax Relief ~~and~~

1 ~~Pharmaceutical Assistance Act~~".

2 (Source: P.A. 84-807; 84-832.)

3 Section 965. The Senior Pharmaceutical Assistance Act is
4 amended by changing Section 5 as follows:

5 (320 ILCS 50/5)

6 Sec. 5. Findings. The General Assembly finds:

7 (1) Senior citizens identify pharmaceutical assistance as
8 the single most critical factor to their health, well-being,
9 and continued independence.

10 (2) The State of Illinois currently operates 2
11 pharmaceutical assistance programs that benefit seniors: (i)
12 the program of pharmaceutical assistance under the Senior
13 Citizens and Disabled Persons Property Tax Relief ~~and~~
14 ~~Pharmaceutical Assistance Act~~ and (ii) the Aid to the Aged,
15 Blind, or Disabled program under the Illinois Public Aid Code.
16 The State has been given authority to establish a third
17 program, SeniorRx Care, through a federal Medicaid waiver.

18 (3) Each year, numerous pieces of legislation are filed
19 seeking to establish additional pharmaceutical assistance
20 benefits for seniors or to make changes to the existing
21 programs.

22 (4) Establishment of a pharmaceutical assistance review
23 committee will ensure proper coordination of benefits,
24 diminish the likelihood of duplicative benefits, and ensure

1 that the best interests of seniors are served.

2 (5) In addition to the State pharmaceutical assistance
3 programs, several private entities, such as drug manufacturers
4 and pharmacies, also offer prescription drug discount or
5 coverage programs.

6 (6) Many seniors are unaware of the myriad of public and
7 private programs available to them.

8 (7) Establishing a pharmaceutical clearinghouse with a
9 toll-free hot-line and local outreach workers will educate
10 seniors about the vast array of options available to them and
11 enable seniors to make an educated and informed choice that is
12 best for them.

13 (8) Estimates indicate that almost one-third of senior
14 citizens lack prescription drug coverage. The federal
15 government, states, and the pharmaceutical industry each have a
16 role in helping these uninsured seniors gain access to
17 life-saving medications.

18 (9) The State of Illinois has recognized its obligation to
19 assist Illinois' neediest seniors in purchasing prescription
20 medications, and it is now time for pharmaceutical
21 manufacturers to recognize their obligation to make their
22 medications affordable to seniors.

23 (Source: P.A. 92-594, eff. 6-27-02.)

24 Section 970. The Illinois Vehicle Code is amended by
25 changing Sections 3-609, 3-623, 3-626, 3-667, 3-683, 3-806.3,

1 and 11-1301.2 as follows:

2 (625 ILCS 5/3-609) (from Ch. 95 1/2, par. 3-609)

3 Sec. 3-609. Disabled Veterans' Plates. Any veteran may make
4 application for the registration of one motor vehicle of the
5 first division or one motor vehicle of the second division
6 weighing not more than 8,000 pounds to the Secretary of State
7 without the payment of any registration fee if (i) the veteran
8 holds proof of a service-connected disability from the United
9 States Department of Veterans Affairs and (ii) a licensed
10 physician, physician assistant, or advanced practice nurse has
11 certified in accordance with Section 3-616 that because of the
12 service-connected disability the veteran qualifies for
13 issuance of registration plates or decals to a person with
14 disabilities. The Secretary may, in his or her discretion,
15 allow the plates to be issued as vanity or personalized plates
16 in accordance with Section 3-405.1 of this Code. Registration
17 shall be for a multi-year period and may be issued staggered
18 registration.

19 Renewal of such registration must be accompanied with
20 documentation for eligibility of registration without fee
21 unless the applicant has a permanent qualifying disability, and
22 such registration plates may not be issued to any person not
23 eligible therefor.

24 The Illinois Department of Veterans' Affairs may assist in
25 providing the documentation of disability.

1 Commencing with the 2009 registration year, any person
2 eligible to receive license plates under this Section who has
3 been approved for benefits under the Senior Citizens and
4 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
5 ~~Assistance~~ Act, or who has claimed and received a grant under
6 that Act, shall pay a fee of \$24 instead of the fee otherwise
7 provided in this Code for passenger cars displaying standard
8 multi-year registration plates issued under Section 3-414.1,
9 for motor vehicles registered at 8,000 pounds or less under
10 Section 3-815(a), or for recreational vehicles registered at
11 8,000 pounds or less under Section 3-815(b), for a second set
12 of plates under this Section.

13 (Source: P.A. 95-157, eff. 1-1-08; 95-167, eff. 1-1-08; 95-353,
14 eff. 1-1-08; 95-876, eff. 8-21-08; 96-79, eff. 1-1-10.)

15 (625 ILCS 5/3-623) (from Ch. 95 1/2, par. 3-623)

16 Sec. 3-623. Purple Heart Plates. The Secretary, upon
17 receipt of an application made in the form prescribed by the
18 Secretary of State, may issue to recipients awarded the Purple
19 Heart by a branch of the armed forces of the United States who
20 reside in Illinois, special registration plates. The
21 Secretary, upon receipt of the proper application, may also
22 issue these special registration plates to an Illinois resident
23 who is the surviving spouse of a person who was awarded the
24 Purple Heart by a branch of the armed forces of the United
25 States. The special plates issued pursuant to this Section

1 should be affixed only to passenger vehicles of the 1st
2 division, including motorcycles, or motor vehicles of the 2nd
3 division weighing not more than 8,000 pounds. The Secretary
4 may, in his or her discretion, allow the plates to be issued as
5 vanity or personalized plates in accordance with Section
6 3-405.1 of this Code. The Secretary of State must make a
7 version of the special registration plates authorized under
8 this Section in a form appropriate for motorcycles.

9 The design and color of such plates shall be wholly within
10 the discretion of the Secretary of State. Appropriate
11 documentation, as determined by the Secretary, and the
12 appropriate registration fee shall accompany the application.
13 However, for an individual who has been issued Purple Heart
14 plates for a vehicle and who has been approved for benefits
15 under the Senior Citizens and Disabled Persons Property Tax
16 Relief ~~and Pharmaceutical Assistance~~ Act, the annual fee for
17 the registration of the vehicle shall be as provided in Section
18 3-806.3 of this Code.

19 (Source: P.A. 95-331, eff. 8-21-07; 95-353, eff. 1-1-08;
20 96-1101, eff. 1-1-11.)

21 (625 ILCS 5/3-626)

22 Sec. 3-626. Korean War Veteran license plates.

23 (a) In addition to any other special license plate, the
24 Secretary, upon receipt of all applicable fees and applications
25 made in the form prescribed by the Secretary of State, may

1 issue special registration plates designated as Korean War
2 Veteran license plates to residents of Illinois who
3 participated in the United States Armed Forces during the
4 Korean War. The special plate issued under this Section shall
5 be affixed only to passenger vehicles of the first division,
6 motorcycles, motor vehicles of the second division weighing not
7 more than 8,000 pounds, and recreational vehicles as defined by
8 Section 1-169 of this Code. Plates issued under this Section
9 shall expire according to the staggered multi-year procedure
10 established by Section 3-414.1 of this Code.

11 (b) The design, color, and format of the plates shall be
12 wholly within the discretion of the Secretary of State. The
13 Secretary may, in his or her discretion, allow the plates to be
14 issued as vanity plates or personalized in accordance with
15 Section 3-405.1 of this Code. The plates are not required to
16 designate "Land Of Lincoln", as prescribed in subsection (b) of
17 Section 3-412 of this Code. The Secretary shall prescribe the
18 eligibility requirements and, in his or her discretion, shall
19 approve and prescribe stickers or decals as provided under
20 Section 3-412.

21 (c) (Blank).

22 (d) The Korean War Memorial Construction Fund is created as
23 a special fund in the State treasury. All moneys in the Korean
24 War Memorial Construction Fund shall, subject to
25 appropriation, be used by the Department of Veteran Affairs to
26 provide grants for construction of the Korean War Memorial to

1 be located at Oak Ridge Cemetery in Springfield, Illinois. Upon
2 the completion of the Memorial, the Department of Veteran
3 Affairs shall certify to the State Treasurer that the
4 construction of the Memorial has been completed. Upon the
5 certification by the Department of Veteran Affairs, the State
6 Treasurer shall transfer all moneys in the Fund and any future
7 deposits into the Fund into the Secretary of State Special
8 License Plate Fund.

9 (e) An individual who has been issued Korean War Veteran
10 license plates for a vehicle and who has been approved for
11 benefits under the Senior Citizens and Disabled Persons
12 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act shall pay
13 the original issuance and the regular annual fee for the
14 registration of the vehicle as provided in Section 3-806.3 of
15 this Code in addition to the fees specified in subsection (c)
16 of this Section.

17 (Source: P.A. 96-1409, eff. 1-1-11.)

18 (625 ILCS 5/3-667)

19 Sec. 3-667. Korean Service license plates.

20 (a) In addition to any other special license plate, the
21 Secretary, upon receipt of all applicable fees and applications
22 made in the form prescribed by the Secretary of State, may
23 issue special registration plates designated as Korean Service
24 license plates to residents of Illinois who, on or after July
25 27, 1954, participated in the United States Armed Forces in

1 Korea. The special plate issued under this Section shall be
2 affixed only to passenger vehicles of the first division,
3 motorcycles, motor vehicles of the second division weighing not
4 more than 8,000 pounds, and recreational vehicles as defined by
5 Section 1-169 of this Code. Plates issued under this Section
6 shall expire according to the staggered multi-year procedure
7 established by Section 3-414.1 of this Code.

8 (b) The design, color, and format of the plates shall be
9 wholly within the discretion of the Secretary of State. The
10 Secretary may, in his or her discretion, allow the plates to be
11 issued as vanity or personalized plates in accordance with
12 Section 3-405.1 of this Code. The plates are not required to
13 designate "Land of Lincoln", as prescribed in subsection (b) of
14 Section 3-412 of this Code. The Secretary shall prescribe the
15 eligibility requirements and, in his or her discretion, shall
16 approve and prescribe stickers or decals as provided under
17 Section 3-412.

18 (c) An applicant shall be charged a \$2 fee for original
19 issuance in addition to the applicable registration fee. This
20 additional fee shall be deposited into the Korean War Memorial
21 Construction Fund a special fund in the State treasury.

22 (d) An individual who has been issued Korean Service
23 license plates for a vehicle and who has been approved for
24 benefits under the Senior Citizens and Disabled Persons
25 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act shall pay
26 the original issuance and the regular annual fee for the

1 registration of the vehicle as provided in Section 3-806.3 of
2 this Code in addition to the fees specified in subsection (c)
3 of this Section.

4 (Source: P.A. 97-306, eff. 1-1-12.)

5 (625 ILCS 5/3-683)

6 Sec. 3-683. Distinguished Service Cross license plates.
7 The Secretary, upon receipt of an application made in the form
8 prescribed by the Secretary of State, shall issue special
9 registration plates to any Illinois resident who has been
10 awarded the Distinguished Service Cross by a branch of the
11 armed forces of the United States. The Secretary, upon receipt
12 of the proper application, shall also issue these special
13 registration plates to an Illinois resident who is the
14 surviving spouse of a person who was awarded the Distinguished
15 Service Cross by a branch of the armed forces of the United
16 States. The special plates issued under this Section should be
17 affixed only to passenger vehicles of the first division,
18 including motorcycles, or motor vehicles of the second division
19 weighing not more than 8,000 pounds.

20 The design and color of the plates shall be wholly within
21 the discretion of the Secretary of State. Appropriate
22 documentation, as determined by the Secretary, and the
23 appropriate registration fee shall accompany the application.
24 However, for an individual who has been issued Distinguished
25 Service Cross plates for a vehicle and who has been approved

1 for benefits under the Senior Citizens and Disabled Persons
2 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act, the
3 annual fee for the registration of the vehicle shall be as
4 provided in Section 3-806.3 of this Code.

5 (Source: P.A. 95-794, eff. 1-1-09; 96-328, eff. 8-11-09.)

6 (625 ILCS 5/3-806.3) (from Ch. 95 1/2, par. 3-806.3)

7 Sec. 3-806.3. Senior Citizens. Commencing with the 2009
8 registration year, the registration fee paid by any vehicle
9 owner who has been approved for benefits under the Senior
10 Citizens and Disabled Persons Property Tax Relief ~~and~~
11 ~~Pharmaceutical Assistance~~ Act or who is the spouse of such a
12 person shall be \$24 instead of the fee otherwise provided in
13 this Code for passenger cars displaying standard multi-year
14 registration plates issued under Section 3-414.1, motor
15 vehicles displaying special registration plates issued under
16 Section 3-609, 3-616, 3-621, 3-622, 3-623, 3-624, 3-625, 3-626,
17 3-628, 3-638, 3-642, 3-645, 3-647, 3-650, 3-651, or 3-663,
18 motor vehicles registered at 8,000 pounds or less under Section
19 3-815(a), and recreational vehicles registered at 8,000 pounds
20 or less under Section 3-815(b). Widows and widowers of
21 claimants shall also be entitled to this reduced registration
22 fee for the registration year in which the claimant was
23 eligible.

24 Commencing with the 2009 registration year, the
25 registration fee paid by any vehicle owner who has claimed and

1 received a grant under the Senior Citizens and Disabled Persons
2 Property Tax Relief ~~and Pharmaceutical Assistance~~ Act or who is
3 the spouse of such a person shall be \$24 instead of the fee
4 otherwise provided in this Code for passenger cars displaying
5 standard multi-year registration plates issued under Section
6 3-414.1, motor vehicles displaying special registration plates
7 issued under Section 3-607, 3-609, 3-616, 3-621, 3-622, 3-623,
8 3-624, 3-625, 3-626, 3-628, 3-638, 3-642, 3-645, 3-647, 3-650,
9 3-651, 3-663, or 3-664, motor vehicles registered at 8,000
10 pounds or less under Section 3-815(a), and recreational
11 vehicles registered at 8,000 pounds or less under Section
12 3-815(b). Widows and widowers of claimants shall also be
13 entitled to this reduced registration fee for the registration
14 year in which the claimant was eligible.

15 No more than one reduced registration fee under this
16 Section shall be allowed during any 12 month period based on
17 the primary eligibility of any individual, whether such reduced
18 registration fee is allowed to the individual or to the spouse,
19 widow or widower of such individual. This Section does not
20 apply to the fee paid in addition to the registration fee for
21 motor vehicles displaying vanity or special license plates.

22 (Source: P.A. 95-157, eff. 1-1-08; 95-331, eff. 8-21-07;
23 95-876, eff. 8-21-08; 96-554, eff. 1-1-10.)

24 (625 ILCS 5/11-1301.2) (from Ch. 95 1/2, par. 11-1301.2)

25 Sec. 11-1301.2. Special decals for parking; persons with

1 disabilities.

2 (a) The Secretary of State shall provide for, by
3 administrative rules, the design, size, color, and placement of
4 a person with disabilities motorist decal or device and shall
5 provide for, by administrative rules, the content and form of
6 an application for a person with disabilities motorist decal or
7 device, which shall be used by local authorities in the
8 issuance thereof to a person with temporary disabilities,
9 provided that the decal or device is valid for no more than 90
10 days, subject to renewal for like periods based upon continued
11 disability, and further provided that the decal or device
12 clearly sets forth the date that the decal or device expires.
13 The application shall include the requirement of an Illinois
14 Identification Card number or a State of Illinois driver's
15 license number. This decal or device may be used by the
16 authorized holder to designate and identify a vehicle not owned
17 or displaying a registration plate as provided in Sections
18 3-609 and 3-616 of this Act to designate when the vehicle is
19 being used to transport said person or persons with
20 disabilities, and thus is entitled to enjoy all the privileges
21 that would be afforded a person with disabilities licensed
22 vehicle. Person with disabilities decals or devices issued and
23 displayed pursuant to this Section shall be recognized and
24 honored by all local authorities regardless of which local
25 authority issued such decal or device.

26 The decal or device shall be issued only upon a showing by

1 adequate documentation that the person for whose benefit the
2 decal or device is to be used has a temporary disability as
3 defined in Section 1-159.1 of this Code.

4 (b) The local governing authorities shall be responsible
5 for the provision of such decal or device, its issuance and
6 designated placement within the vehicle. The cost of such decal
7 or device shall be at the discretion of such local governing
8 authority.

9 (c) The Secretary of State may, pursuant to Section
10 3-616(c), issue a person with disabilities parking decal or
11 device to a person with disabilities as defined by Section
12 1-159.1. Any person with disabilities parking decal or device
13 issued by the Secretary of State shall be registered to that
14 person with disabilities in the form to be prescribed by the
15 Secretary of State. The person with disabilities parking decal
16 or device shall not display that person's address. One
17 additional decal or device may be issued to an applicant upon
18 his or her written request and with the approval of the
19 Secretary of State. The written request must include a
20 justification of the need for the additional decal or device.

21 (d) Replacement decals or devices may be issued for lost,
22 stolen, or destroyed decals upon application and payment of a
23 \$10 fee. The replacement fee may be waived for individuals that
24 have claimed and received a grant under the Senior Citizens and
25 Disabled Persons Property Tax Relief ~~and Pharmaceutical~~
26 ~~Assistance~~ Act.

1 (Source: P.A. 95-167, eff. 1-1-08; 96-72, eff. 1-1-10; 96-79,
2 eff. 1-1-10; 96-1000, eff. 7-2-10.)

3 Section 975. The Criminal Code of 1961 is amended by
4 changing Section 17-6.5 as follows:

5 (720 ILCS 5/17-6.5)

6 Sec. 17-6.5. Persons under deportation order;
7 ineligibility for benefits.

8 (a) An individual against whom a United States Immigration
9 Judge has issued an order of deportation which has been
10 affirmed by the Board of Immigration Review, as well as an
11 individual who appeals such an order pending appeal, under
12 paragraph 19 of Section 241(a) of the Immigration and
13 Nationality Act relating to persecution of others on account of
14 race, religion, national origin or political opinion under the
15 direction of or in association with the Nazi government of
16 Germany or its allies, shall be ineligible for the following
17 benefits authorized by State law:

18 (1) The homestead exemptions and homestead improvement
19 exemption under Sections 15-170, 15-175, 15-176, and
20 15-180 of the Property Tax Code.

21 (2) Grants under the Senior Citizens and Disabled
22 Persons Property Tax Relief ~~and Pharmaceutical Assistance~~
23 Act.

24 (3) The double income tax exemption conferred upon

1 persons 65 years of age or older by Section 204 of the
2 Illinois Income Tax Act.

3 (4) Grants provided by the Department on Aging.

4 (5) Reductions in vehicle registration fees under
5 Section 3-806.3 of the Illinois Vehicle Code.

6 (6) Free fishing and reduced fishing license fees under
7 Sections 20-5 and 20-40 of the Fish and Aquatic Life Code.

8 (7) Tuition free courses for senior citizens under the
9 Senior Citizen Courses Act.

10 (8) Any benefits under the Illinois Public Aid Code.

11 (b) If a person has been found by a court to have knowingly
12 received benefits in violation of subsection (a) and:

13 (1) the total monetary value of the benefits received
14 is less than \$150, the person is guilty of a Class A
15 misdemeanor; a second or subsequent violation is a Class 4
16 felony;

17 (2) the total monetary value of the benefits received
18 is \$150 or more but less than \$1,000, the person is guilty
19 of a Class 4 felony; a second or subsequent violation is a
20 Class 3 felony;

21 (3) the total monetary value of the benefits received
22 is \$1,000 or more but less than \$5,000, the person is
23 guilty of a Class 3 felony; a second or subsequent
24 violation is a Class 2 felony;

25 (4) the total monetary value of the benefits received
26 is \$5,000 or more but less than \$10,000, the person is

1 guilty of a Class 2 felony; a second or subsequent
2 violation is a Class 1 felony; or

3 (5) the total monetary value of the benefits received
4 is \$10,000 or more, the person is guilty of a Class 1
5 felony.

6 (c) For purposes of determining the classification of an
7 offense under this Section, all of the monetary value of the
8 benefits received as a result of the unlawful act, practice, or
9 course of conduct may be accumulated.

10 (d) Any grants awarded to persons described in subsection
11 (a) may be recovered by the State of Illinois in a civil action
12 commenced by the Attorney General in the circuit court of
13 Sangamon County or the State's Attorney of the county of
14 residence of the person described in subsection (a).

15 (e) An individual described in subsection (a) who has been
16 deported shall be restored to any benefits which that
17 individual has been denied under State law pursuant to
18 subsection (a) if (i) the Attorney General of the United States
19 has issued an order cancelling deportation and has adjusted the
20 status of the individual to that of an alien lawfully admitted
21 for permanent residence in the United States or (ii) the
22 country to which the individual has been deported adjudicates
23 or exonerates the individual in a judicial or administrative
24 proceeding as not being guilty of the persecution of others on
25 account of race, religion, national origin, or political
26 opinion under the direction of or in association with the Nazi

1 government of Germany or its allies.

2 (Source: P.A. 96-1551, eff. 7-1-11.)

3 Section 995. Severability. If any provision of this Act or
4 application thereof to any person or circumstance is held
5 invalid, such invalidity does not affect other provisions or
6 applications of this Act which can be given effect without the
7 invalid application or provision, and to this end the
8 provisions of this Act are declared to be severable.

9 Section 999. Effective date. This Act takes effect upon
10 becoming law, except that Sections 15, 20, 30, and 85 take
11 effect on July 1, 2012.".